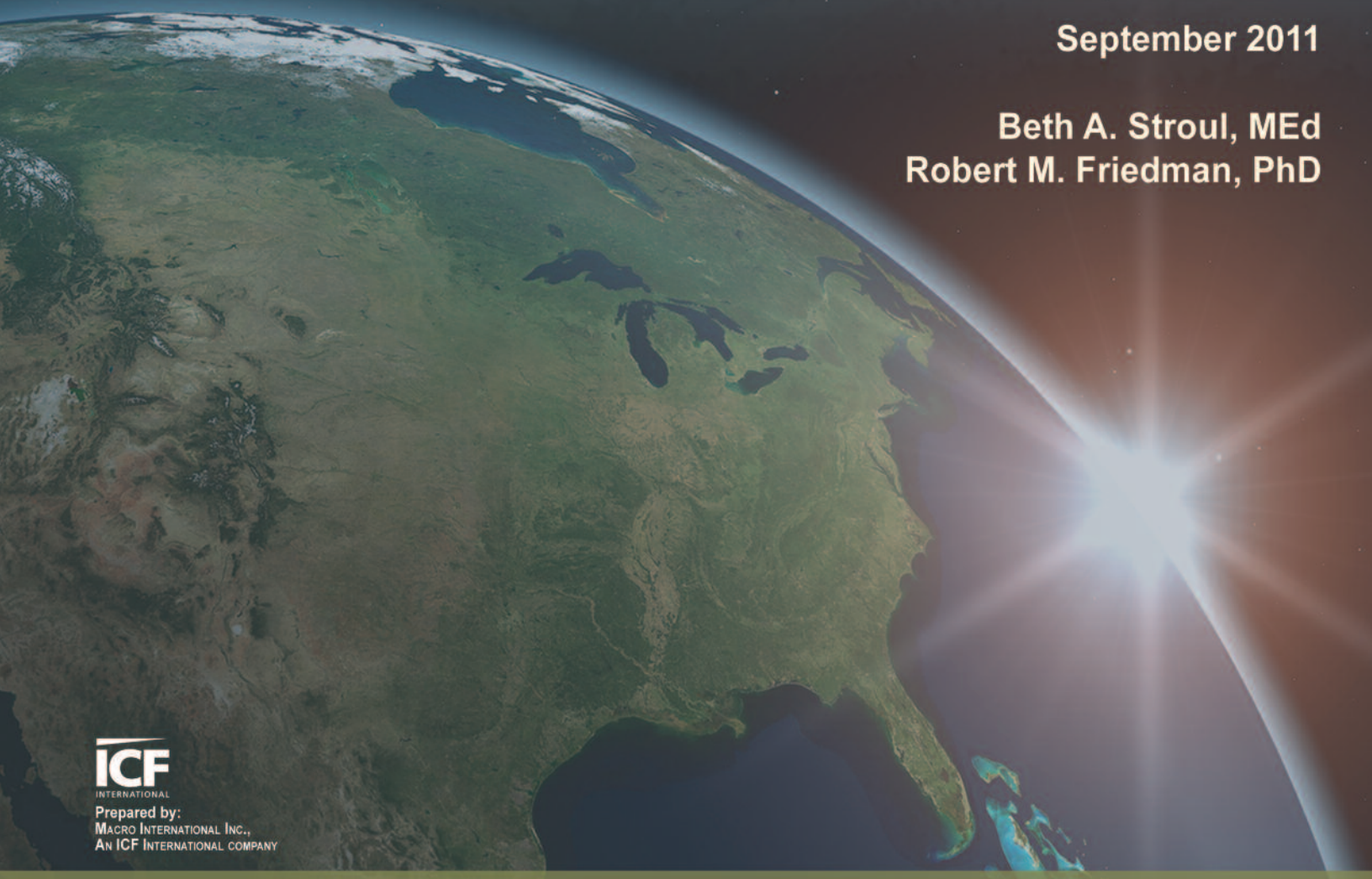
EFFECTIVE STRATEGIES FOR EXPANDING THE SYSTEM OF CARE APPROACH

A Report on the Study of Strategies for Expanding Systems of Care

National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program



September 2011

Beth A. Stroul, MEd
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Substance Abuse and Mental Health Services Administration
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ACKNOWLEDGMENTS

This report presents the findings from a study on effective strategies for expanding the system of care approach that was undertaken as part of the national evaluation of the federal Comprehensive Community Mental Health Services for Children and Their Families Program. The study and report benefitted from the input and assistance of many people. The directors of children's mental health in the nine states that participated in the study not only allowed themselves to be interviewed, but also enlisted others to be part of the study. In total, 52 individuals were interviewed, and the authors are most appreciative of their time and contributions.

Throughout each stage of the study, leaders in children's mental health from around the country contributed their ideas and feedback. Local, state, and federal policy makers and administrators; service providers; family members; youth; researchers; and technical assistance providers all offered valuable and much appreciated input. Although these individuals are too numerous to acknowledge individually, this study could not have been conducted without their assistance.

Special appreciation is due to Gary Blau, PhD, chief of the Child, Adolescent and Family Branch of the federal Center for Mental Health Services, and Brigitte Manteuffel, PhD, of ICF Macro, principal investigator for the national evaluation of the federal Children's Mental Health Initiative, for their guidance every step of the way and their careful review of this report. Their comments and suggestions strengthened the study and the report immeasurably. The collaboration and support of the National Technical Assistance Center for Children's Mental Health at Georgetown University, in particular Sybil Goldman, MSW, and the Department of Child and Family Studies of the University of South Florida were also very helpful.

As authors of this report, we hope that we have captured the important ideas and information that so many people have contributed. Twenty-five years ago, we had the privilege of preparing the first monograph on systems of care based on input from many individuals, field experience, and the best available research. We are gratified at the tremendous progress that has been made since that monograph was published in 1986. Now, as the system of care approach advances to this next stage of maintaining quality while expanding within states, tribes, and territories throughout the country, we were again privileged to have the opportunity to listen to and learn from many talented and committed individuals. We hope that this report will advance the important efforts to improve services and outcomes across the country for children, youth, and young adults with mental health challenges and their families.

Beth A. Stroul
Robert M. Friedman

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EXECUTIVE SUMMARY

Systems of care are designed to provide effective services and supports that enable children and youth with mental health challenges and their families to function well in their homes and communities and to lead productive lives. The concept, first developed in the mid-1980s, is based on a philosophy that emphasizes services that are community based, family driven, youth guided, individualized, coordinated, and culturally and linguistically competent. In 1992, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched a competitive grant program in an effort to translate this concept into system reforms and concrete services that would benefit children, youth, and families. The program, known as the Children's Mental Health Initiative (CMHI), provides funds to communities, states, tribes, and territories to implement systems of care. As of 2011, the CMHI has invested more than $1.6 billion in grants and cooperative agreements to 173 communities in all 50 states, Puerto Rico, Guam, the District of Columbia, 21 American Indian/Alaska Native communities.

Evaluations have shown the system of care approach to be successful both in contributing to system reforms and in improving outcomes for children, youth, and families. As a result, SAMHSA has increased its focus on expanding systems of care so that more individuals in need will be able to access effective services consistent with the system of care approach. As this goal came into sharper focus, it became clear that a number of states have already made significant progress in expanding the system of care approach. It was also recognized that the experience of those states could inform SAMHSA's work in promoting the widespread adoption of systems of care, as well as efforts in the field to implement the approach statewide and throughout tribes and territories.

This report describes a project designed to study states that have made considerable progress in expanding systems of care and to identify the strategies that have helped them to accomplish this goal. The study was undertaken to obtain practical information that would support governments at all levels in their efforts to expand the approach by identifying and describing the most effective strategies that successful states have undertaken.

A nomination process by a diverse group of experts in the field led to a sample of nine states being selected for inclusion in the study: Arizona, Hawaii, Maine, Maryland, Michigan, New Jersey, North Carolina, Oklahoma, and Rhode Island. These states were selected from among those that have successfully expanded systems of care. The goal was to select a sample that differs in size, governmental structure, geography, and demographics. Each of these states has received at least one system of care grant or cooperative agreement as part of the CMHI. In aggregate, the nine states have received at total 31 CMHI grants or cooperative agreements.

On the basis of input from advisors, the results of previous research on the sustainability of systems of care, and a review of the literature, a conceptual framework was developed. The framework is comprised of five general types of expansion strategies that states might employ:

- Implementing policy, administrative, and regulatory changes
- Developing or expanding services and supports based on the system of care philosophy and approach

- Creating or improving financing strategies
- Providing training, technical assistance, and coaching
- Generating support for the system of care approach

Within each of these five core strategy areas, a set of more specific sub-strategies was identified. For example, specific sub-strategies for creating or improving financing strategies include increasing the use of Medicaid, increasing the use of federal grants, and increasing the use of funds from other child-serving systems.

The list of strategies within the framework was then converted into a protocol to be used as part of a semistructured interview process with key informants from each state. The informants included, at a minimum, the state director of children's mental health, a leader in the family movement in the state, and a system of care leader from a local community. A total of 52 interviews with different individuals were conducted (four to seven interviewees per state), thereby ensuring that multiple perspectives were obtained and that there was an opportunity to look for convergence or divergence in perspectives.

The informants were asked to identify which strategies were used, to assess their effectiveness, and to provide examples of how the particular strategies were used. Interviewees were also asked to make overall judgments about the strategies they believed to be the most effective. Additional information was obtained about barriers to expansion, the role that current or former CMHI-funded system of care communities played in statewide expansion, and the value of the supports provided by SAMHSA.

Eight strategies stood out as being the most significant and effective, based on the responses of the interviewees:

- Incorporating requirements for adherence to the system of care philosophy and approach in requests for proposals, contracts, and regulations
- Providing training, TA, and coaching on the system of care approach
- Creating or assigning clear focal points of management and accountability for system of care development and expansion at state and local levels
- Expanding the array of available services and supports, with particular focus on home- and community-based services
- Expanding an individualized, wraparound approach to service planning and delivery
- Expanding family and youth involvement in service planning and delivery
- Creating strong family organizations that helped to generate support for systems of care with important constituencies
- Increasing the use Medicaid to finance services and supports

In addition, several strategies were identified as underutilized—strategies that could have been but were not used extensively for expansion purposes in the sample of states. Some of these underutilized strategies have the potential to advance expansion efforts:

- Securing, blending, or braiding funding across child-serving systems
- Using data on cost avoidance due to reductions in the use of costly residential placements to help build the case for systems of care
- Promoting cultural and linguistic competence as an expansion strategy
- Using social marketing and strategic communications more effectively

The findings from the interviews indicated that respondents in several states attributed their success in expanding systems of care in large part to the CMHI system of care grants that they had received. These grants helped them to build an infrastructure to support systems of care, allowed them to test out new approaches, provided them with effectiveness data, helped them to strengthen family and youth organizations, and assisted them in providing training and technical assistance to nonfunded communities.

Overall, it was concluded from this study that some states have not only have made considerable progress in expanding systems of care but have been able to maintain that progress during difficult budgetary times and amid changes in elected leaders and administrators. The strategies that these states considered to be most effective for expanding the system of care approach have much to offer to other states, tribes, territories, and communities.

Although successful states embraced some similar strategies, they followed unique pathways to success based on their own visions, their carefully crafted plans, and opportunities presented to them, some of which were unanticipated. In some states, for example, class-action lawsuits provided an opportunity to reform service delivery systems and practices in accordance with the system of care philosophy.

Successful states had strong and deep commitments to system of care values and principles, created plans with multiple strategies, and had outstanding individual and collective leadership. These states and their leaders were strategic, collaborative, flexible, and adaptive and had high standards for quality of care. They formed close partnerships with family and youth organizations and often with leaders of multiple child-serving systems. The pathway to success for these states was not necessarily straight and clear; however, they have made substantial progress through persistence, commitment, flexibility, opportunism, openness to new learning, and leadership—all rooted in a set of values and principles that they believe in strongly.

The lessons learned from this study are intended to inform the future efforts of states, tribes, territories, and communities to expand the system of care approach. The findings can also serve to inform SAMHSA and other federal agencies about how investments in innovative approaches can be moved from demonstrations in selected areas to widespread adoption.

CHAPTER 1: BACKGROUND

Since 1992, the federal Comprehensive Community Mental Health Services for Children and Their Families Program (or the Children's Mental Health Initiative [CMHI]) has invested resources in implementing the system of care approach in communities across the Nation. With a strong history of demonstrating the effectiveness of this approach, the Substance Abuse and Mental Health Services Administration (SAMHSA) is turning its attention to strategies for expanding systems of care throughout states, tribes, and territories (hereafter referred to as states) (SAMHSA, 2011). To support this new focus, a study was developed to identify lessons that can be learned from a diverse group of states that have made significant progress in promoting the widespread adoption of systems of care. This report is a product of that study and is an outgrowth of efforts across the country to achieve the large-scale system changes that are required to expand the system of care approach. The report begins with background information, a summary of the study method, and a description of the conceptual framework developed for the study. Subsequent chapters summarize each state's overall approach to expansion and present study findings, including those strategies found to be most effective as those that were underutilized. Discussions of findings are illustrated with specific examples of strategies that were used in the states studied. The report concludes with a discussion of lessons learned that will serve to inform the future efforts of states and communities to expand the system of care approach.

THE SYSTEM OF CARE APPROACH

The children's mental health field took a major step forward in the mid-1980s with the initiation of the Child and Adolescent Service System Program (CASSP). That program provided modest funding to states to enhance their capacity to improve children's mental health services and introduced the concept of a system of care that has served as a foundation for systems and services for more than 25 years.

In 1986, with the publication of the first monograph on a system of care, the concept was translated into an organizational framework and philosophy that has provided direction and guidance to the field ever since. Originally defined as a "comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families" (Stroul & Friedman, 1986, p. 3; Stroul & Friedman, 1996), the approach has gained broad acceptance. In fact, the system of care approach has reshaped children's mental health services to the extent that at least some elements of the system of care philosophy and approach can be found in nearly all communities across the nation (Stroul, Blau, & Friedman, 2010). The approach has also been extensively adopted by child welfare, juvenile justice, education, and substance use treatment and prevention systems; early childhood programs; systems that serve youth and young adults in transition to adulthood; and even by many adult-serving systems.

Although the system of care approach continues to evolve to reflect advances in research and service delivery, the core values of community-based, family-driven, youth-guided, and culturally and linguistically competent services are widely accepted. The guiding principles calling for a broad array of effective services, individualized care, and coordination across child-serving systems are extensively used as the standards of care throughout the Nation. A recently

updated definition of the system of care concept and philosophy is shown below (Stroul, Blau, & Friedman, 2010).

System of Care Concept and Philosophy

DEFINITION

A system of care is:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

CORE VALUES

Systems of care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports

GUIDING PRINCIPLES

Systems of care are designed to:

1. Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports
2. Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family
3. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate
4. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their communities, states, territories, tribes, and Nation
5. Ensure cross-system collaboration, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management
6. Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs
7. Provide developmentally appropriate mental health services and supports that promote optimal social and emotional outcomes for young children and their families in their homes and community settings
8. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult-service system as needed

System of Care Concept and Philosophy (continued)

GUIDING PRINCIPLES

Systems of care are designed to:

9. Incorporate or link with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents
10. Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level
11. Protect the rights of children, youth, and families and promote effective advocacy efforts
12. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; services should be sensitive and responsive to these differences

CHILDREN'S MENTAL HEALTH INITIATIVE

In 1992, in an effort to translate the philosophy and approach into concrete services that would benefit children and youth with severe mental health challenges and their families, SAMHSA launched a competitive grant program to provide funding for communities to implement systems of care. This program, the Comprehensive Community Mental Health Services for Children and Their Families Program, includes strong national technical assistance (TA) and evaluation components in addition to the grants to directly assist communities and states (Stroul, Blau, & Sondheimer, 2008). As of 2011, the CMHI has invested more than $1.6 billion to 173 communities in all 50 states, Puerto Rico, Guam, the District of Columbia, and 21 American Indian/Alaska Native tribes or tribal entities. Initially in the form of grants, the funding subsequently took the form of cooperative agreements (hereafter referred to collectively as grants).

The program was originally structured to provide time-limited demonstration grants of 5 years' duration, but the legislation was later modified to add a sixth year. An increasingly explicit goal has been to develop systems of care that not only provide effective services for children, youth, and families in funded communities, but that achieve system reforms that are sustained after the grants end, and impact communities around the country regardless of whether they actually receive a grant. Such an impact has been achieved through developing effective strategies for implementing systems of care, collecting outcome data that demonstrate positive effects, building strong constituencies for systems of care, and widely disseminating the information that had been gathered.

From the outset, systems of care were conceptualized as complex, multifaceted, and multilevel interventions that would be based on a common philosophy and set of values and principles. A strength of the approach is it can be adapted to the local contexts and needs of diverse communities, so long as it remains consistent with the system of care values. In fact, systems of care are dynamic and evolving in response to the development of new knowledge, findings from evaluations, and changing state and local environments.

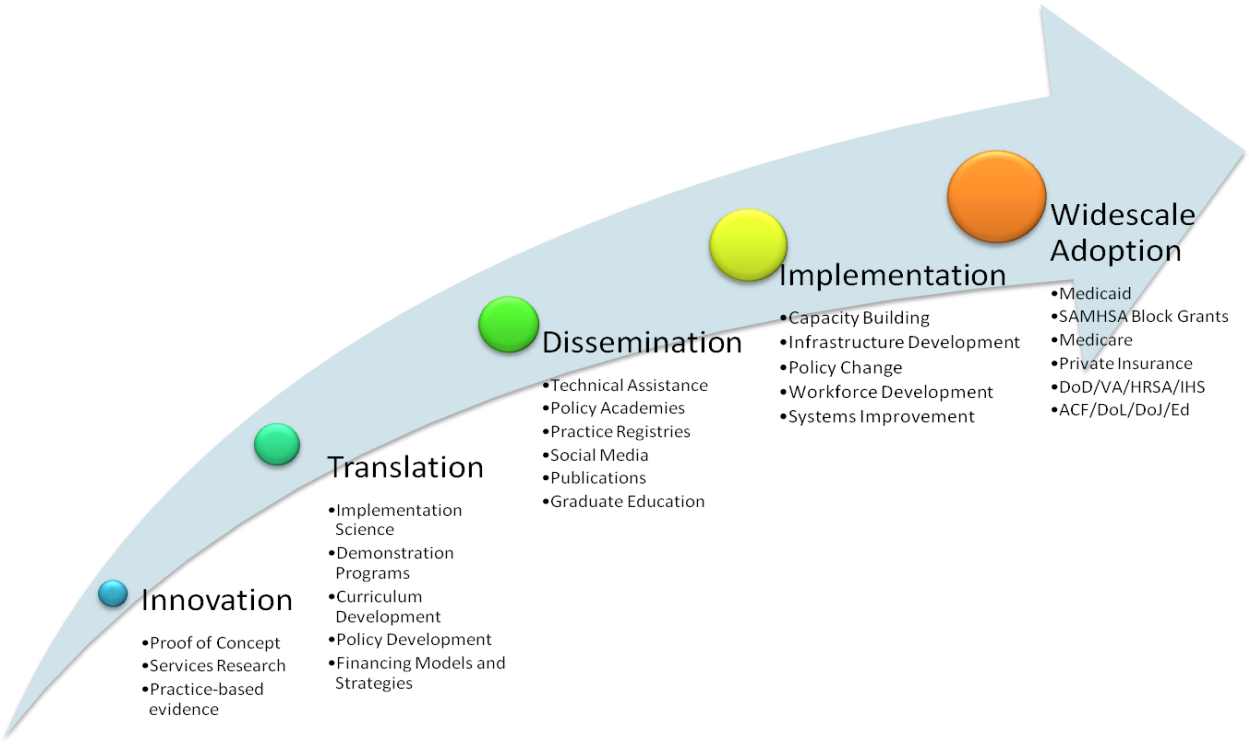
EXPANDING THE SYSTEM OF CARE APPROACH

Extensive evaluation and research have documented the effectiveness of the system of care approach (Manteuffel, Stephens, Brashears, Krivelyova, & Fisher, 2008). The national evaluation of the CMHI has consistently found that implementation of the approach at the system and service delivery levels results in positive outcomes. With changes in service delivery and front-line practice, children and youth have demonstrated improvements in clinical and functional outcomes, increases in behavioral and emotional strengths, reductions in suicide attempts, improvements in school performance and attendance, fewer contacts with law enforcement, reductions in reliance on inpatient care, and more stable living situations. Data also have shown that the caregivers of children and youth served within systems of care experience reduced strain associated with caring for a child or youth who has a serious mental health condition, more adequate resources, fewer missed days of work due to the mental health needs of their child, and improvement in overall family functioning (Manteuffel et al., 2008).

In addition, evaluation of the CMHI at the system level has shown that grantees change their policies, infrastructure, and services in accordance with the system of care philosophy. The evaluation has also shown that the system of care approach is a cost-effective way of investing resources by redirecting funds from deep-end services (inpatient and residential treatment) to home- and community-based services and supports (Gruttadaro et al. 2009; Maine Department of Health and Human Services, 2011; Maryland Child and Adolescent Innovations Institute, 2008: Manteuffel et al., 2008). As a result of these positive outcomes, SAMHSA launched a new effort to further this progress by providing funds to states to develop comprehensive strategic plans for widespread expansion of the system of care approach so that more children, youth, and families can benefit (SAMHSA, 2011).

The system of care expansion initiative is consistent with SAMHSA's theory of change, which takes an innovation—in this instance the system of care approach—through the stages of conceptual development, implementation as demonstrations, dissemination, capacity building for broader implementation, and finally to widespread adoption (Blau, 2011). With the demonstration of the system of care approach in states and communities across the Nation, and with the documented positive results, the approach has reached the stage of readiness for broad-based implementation in service delivery systems. SAMHSA's System of Care Expansion Planning Grant program is intended as a step toward achieving the ultimate objective in SAMHSA's theory of change. The current study on strategies for expanding the system of care approach will inform the work of states as they develop and implement system of care expansion plans through this program.

Figure 1. SAMHSA Theory of Change



STUDY ON STRATEGIES FOR EXPANDING THE SYSTEM OF CARE APPROACH

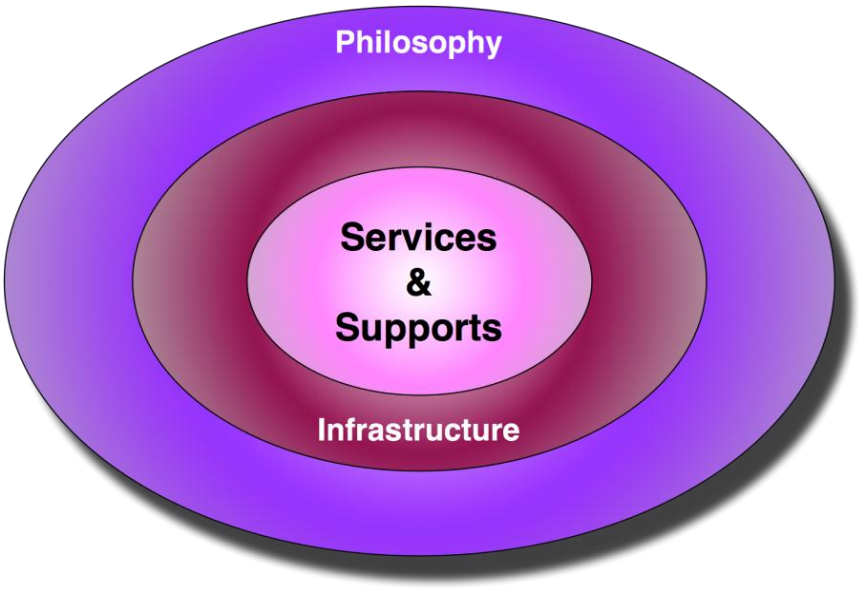
The importance of state-level system changes for sustaining and expanding the system of care approach was underscored by a study on sustainability undertaken as part of the national evaluation of the CMHI (Stroul & Manteuffel, 2008). State agencies play a crucial role in providing both leadership and resources; the study confirmed the difficulty in sustaining and expanding systems of care without state policy and financial support. Specifically, the study found that state strategies were necessary, including (a) incorporating the approach in policy documents, plans, guidance, regulations, and contracts with providers; (b) implementing long-term financing strategies; (c) establishing partnerships across child-serving agencies; (d) implementing new services statewide; (e) providing training and TA; (f) removing barriers in policy, regulations, and financing identified by communities; (g) and monitoring compliance with the approach and evaluating outcomes.

Another finding was that building on the system development work in funded communities by using the communities as pilots or models and as sources of experience, information, and training contributed substantially to expansion of the approach statewide. The study on sustainability laid the groundwork for this current study by beginning to examine state strategies for system change. The current study focused on enhancing this knowledge base by identifying effective state-level strategies based on the experience of nine states that have made significant progress in expanding systems of care.

Overall Framework

At its broadest level, the framework for the study conceptualized systems of care as having three major, interrelated components—an array of services, a supportive infrastructure, and an underlying philosophy that guides the system and its component services, as shown in Figure 2. Specifically, these encompass (a) a set of values and principles; (b) an infrastructure (including governance structures; financing for a wide range of services and supports; partnerships among child-serving agencies, providers, families, and youth; provider networks; capacity for planning, evaluation, and quality improvement); and (c) actual interactions with children, youth, and families at the service delivery level that are consistent with the system of care philosophy. The study focused on the expansion of these major elements of the system of care approach.

Figure 2. Elements of the System of Care Approach



The study team then developed a strategic framework to guide data collection that focused specifically on expanding systems of care. The framework built on prior research on making and sustaining system change, particularly the previous sustainability studies that were part of the national evaluation for the CMHI (Stroul & Manteuffel, 2007; 2008). In addition, the framework was based on a review of the literature and the input of the expert advisors. The framework included five core strategy areas for system change:

- Implementing policy, administrative, and regulatory changes
- Developing or expanding services and supports based on the system of care philosophy and approach
- Creating or improving financing strategies
- Providing training, TA, and coaching
- Generating support for the system of care approach

Within each of these broad core strategies, more specific sub-strategies were identified. For example, specific sub-strategies for creating or improving financing strategies included increasing the use of Medicaid, increasing the use of federal grants, increasing the use of funds from other child-serving systems, and redeploying funds from higher cost services to lower cost services. These are discussed with the presentation of findings in Chapter 3.

Method

Study Design—During the study design process, the team sought input from a diverse group of advisors that met in March 2009. The advisory group included youth and family representatives; individuals who worked at local, state, and federal levels; evaluators; and TA leaders working in multiple communities and states. Because the purpose of the study was to identify the strategies that had been the most helpful to states in expanding the system of care approach, the decision was made to focus attention on a limited number of states that had already made significant progress in expansion.

In each state, telephone interviews were conducted with the state director of children's mental health, a local system of care leader, and a family representative to obtain multiple perspectives. The goal was to interview at least two other individuals per state but to remain flexible in selecting additional interviewees based on information about who else played an important role. The study team gathered information on the developmental process within each state that led to their progress in system of care expansion.

State Selection—The study team sought to select nine states that were diverse in size, structure, geography, and demographics to obtain a spectrum of perspectives within a small sample. The first stage in state selection was to obtain input from the advisory group that met in March 2009 and identified states that had made significant progress in expanding the system of care approach statewide. Also, responses from a brief survey of state children's mental health directors on sustaining and expanding systems of care, conducted by the National Technical Assistance Center for Children's Mental Health at Georgetown University, were reviewed to obtain additional information on nominated states. These recommendations and review of the survey results led to 15 states being identified for potential inclusion in the sample.

To narrow the number of states included in the study, screening interviews were conducted with the children's mental health director in each of the 15 states. They were asked about efforts to sustain and expand systems of care, the strategies that had been implemented, how federally funded grant communities had been engaged in the process, and the current status of systems of care in the state. Results of the screening interviews were summarized and additional input was obtained from several members of the advisory group who were familiar with multiple states. On the basis of the results of the screening process, nine states were invited to participate in the study; the children's mental health director in each state agreed to participate.

The final sample included states from each region of the country, ranging in population from just over 1 million (Rhode Island) to just under 10 million (Michigan). The heaviest concentration of states was in the Northeast (Maine, New Jersey, and Rhode Island). The number of counties per state ranged from 3 in Hawaii to 100 in North Carolina. About 20 percent of the population in the states chosen for the study sample was considered to be rural, which is about the same percentage as for the entire country. The sample included states in which funding for children's

mental health is primarily controlled at the state level (e.g., Hawaii, Maine, and Oklahoma) and states in which counties or multicounty regions have greater control of funding (e.g., Michigan and North Carolina). Table 1 indicates the states included in the sample, their populations as of the 2010 census, and the number of counties in each state.

Table 1. States in the Study, Population, and Number of Counties

State	Population	No. of Counties
Arizona	6,412,700	15
Hawaii	1,366,862	3
Maine	1,333,074	16
Maryland	5,789,929	23 + Baltimore city
Michigan	9,911,626	83
New Jersey	8,807,501	21
North Carolina	9,565,781	100
Oklahoma	3,764,882	77
Rhode Island	1,055,247	5

Each of these states has received at least one prior system of care grant as part of the federal CMHI. New Jersey is at the low end of this range, having received only one grant, while Michigan is at the high end, having received six grants. As shown in Table 2, there have been 31 grants across all states.

Table 2. Number of System of Care Grants in States in the Study Sample

State	Number of Grants
Arizona	2
Hawaii	3
Maine	3
Maryland	4
Michigan	6
New Jersey	1
North Carolina	5
Oklahoma	4
Rhode Island	3
TOTAL	**31**

Instruments and Data Collection—The conceptual framework comprising the five core strategy areas was the basis for development of a semistructured interview protocol to determine which strategies had been used in each state and which were judged to be effective. For each strategy and its component sub-strategies, interviewees were asked to (a) indicate whether they used the strategy for system of care expansion, (b) rate the effectiveness of the strategy on a five-point Likert scale, and (c) provide an example of how the strategy was used.
The protocol also was designed to gather background information from each informant on their overall state strategy for expanding the system of care approach. In addition, the protocol included items on (a) additional strategies that had been used but were not included in the protocol, (b) how federally funded or graduated sites from the CMHI had contributed to system of care expansion efforts, (c) barriers encountered in expanding systems of care, and (d) federal activities and supports that had been helpful to them in the expansion process. Finally, the protocol included a query about which strategies had been the most effective across all of the five core strategy areas.

Interviews were conducted by one of the two investigators by telephone, with the exception of Maryland where both investigators conducted an in-person interview with three of the key informants. While conducting interviews, the study team discussed the data collection process and made minor adjustments to the interview protocol to clarify the intent of questions.

Table 3 shows the roles of the interviewees across states and the number of individuals interviewed by role.

Table 3. Roles of Interviewees

Roles	No. of Interviewees
State Children's Mental Health Directors	9
Other State Mental Health Agency Representatives	10
Other Child-Serving State Agency Representatives	3
Family Leaders	11
Local System of Care and Children's Mental Health Leaders	16
Youth Leaders	1
University Representatives	2
TOTAL	**52 (4–7 per state)**

Data Analysis—For each interview, responses were recorded and a summary report was prepared for each state. Where there were differences of opinion among interviewees for a particular state, the study team reviewed the original data collection protocols to determine whether the data did, in fact, indicate genuine areas of disagreement, whether further clarification was needed, or whether there appeared to be an error. If further clarification was needed, additional information was requested from the interviewees. In instances where there were different perspectives among interviewees, the study team reflected these differences in their state reports and analyses.

The study team also examined the data from the informants on the most important strategies and the most significant barriers. In addition, the overall state reports were examined to identify strategies that were reported to be used infrequently across states and, therefore, were classified as underutilized. Within this category were strategies that had not been used in most states, but that were considered to have the potential to advance expansion.

A preliminary set of findings was developed and presented at a second advisory group meeting held in March 2011. This advisory group, while somewhat different from the group that had been convened previously, also included youth and family representatives and representatives from local, state, and federal levels. TA and evaluators also participated. The advisory group was asked to determine whether the findings were clear, whether they were consistent with their own experiences, and whether they had any questions concerning the findings. The group was also asked to provide their assessments of the primary implications of the findings and their thoughts on how findings could best be presented.

This report represents the product of this study. It is intended to provide information that will assist states, tribes, and territories in developing and implementing effective strategies to expand the system of care approach. The findings can also serve to inform SAMHSA and other federal agencies about how investments in innovative approaches can be moved from demonstrations in selected areas to widespread adoption.

CHAPTER 2: OVERVIEW OF STATE APPROACHES TO SYSTEM OF CARE EXPANSION

This chapter provides a brief description of each state included in the study sample and its overall approach to system of care expansion. In addition, the role of funded and graduated system of care communities in expansion efforts is discussed.

ARIZONA

State Characteristics

The Arizona State Medicaid agency contracts with the Arizona Department of Health Services, Division of Behavioral Health Services to manage a behavioral health carve-out. The Division of Behavioral Health Services, in turn, contracts with four Regional Behavioral Health Authorities (RBHAs) that cover six geographic regions throughout the state and with two tribal Behavioral Health Authorities. These entities manage behavioral health service delivery for both children and adults in their respective areas.

In 1993, an Early Periodic Screening, Diagnosis and Treatment (EPSDT)–related lawsuit, known as Jason K or JK, was filed in the state on behalf of 34,000 Medicaid-eligible class members under age 21 who were in need of behavioral health services. The lawsuit was settled in 2001, and the settlement agreement formed the basis for the state's current children's behavioral health system.

Demographics

Arizona has a population of about 6.4 million, with 24.6 percent under age 18. More than half of the state's population resides in Maricopa County (Phoenix), with an estimated population of more than 4.3 million. According to the 2010 census, the racial and ethnic makeup of the state population was 73.0 percent White, 4.1 percent Black or African–American, 4.6 percent American Indian/Alaska Native, 2.8 percent Asian, 0.2 percent Native Hawaiian and Other Pacific Islander, 11.9 percent some other race, and 3.4 percent two or more races. Hispanics or Latinos of any race made up 29.6 percent of the state's population. Arizona is home to the largest number of speakers of Native American languages in the 48 contiguous states, with more than 85,000 individuals speaking Navajo and more than 10,000 persons reporting Apache as the language spoken at home. The state is divided into 15 counties.

Overall Strategy

Arizona has a specific focus on expanding systems of care statewide. The impetus was the settlement agreement related to the JK class-action lawsuit, which has had an enormous impact on transforming the system to provide mental health services to children at home and in their communities. Twelve principles were developed to guide the behavioral health system, reflecting the system of care concept and philosophy:

1. Collaboration with the child and family
2. Functional outcomes
3. Collaboration with others
4. Accessible services
5. Best practices
6. Most appropriate setting

7. Timeliness
8. Services tailored to the child and family
9. Stability
10. Respect for the child and family's unique cultural heritage
11. Independence
12. Connection to natural supports

The system of care expansion effort in Arizona is guided by an annual plan that has broad goals and objectives. Each region is required to develop its own plan in accordance with state-level objectives. Contracts with the RBHAs and, in turn, their contracts with providers reflect the implementation of these plans for statewide system of care development. The plans are monitored for compliance.

The systems of care have the following key features:

1. Implementing family-driven, youth-guided care
2. Meeting the needs of children with complex needs
3. Providing services for transition-age youth
4. Using wraparound and child and family team practice (all Medicaid-eligible children are entitled to child and family team practice)
5. Providing direct support and rehabilitative services (Meet Me Where We Are campaign)
6. Developing high-needs care management with 1:15 ratio

In addition, specialty providers skilled in serving young children (aged 0–5) and their families and individuals with substance use disorders, sexual behavior problems, and developmental disabilities have been added to the provider network.

The most significant expansion strategies include:

- Planning strategically for implementation of the JK settlement based on the system of care approach
- Expanding the services covered under Medicaid
- Adopting the child and family team process for service planning and delivery statewide
- Implementing direct support and rehabilitative services statewide

Strategic Use of Grants

Arizona System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Project MATCH, Pima County	1999
Sewa Uusim/Flower Children, Our Hope, Our Light, Our Future, Pascua Yaqui Tribe	2006

Arizona had one early system of care grant in Pima County and one tribal grant. The Pima County grant came at an important point in the process of system of care implementation because negotiations for the JK lawsuit were taking place at that time. The state also implemented a pilot of the system of care approach in Maricopa County as a first step in its response to the class-action settlement agreement. Experience from both pilots has been used in conceptualizing and implementing approaches in the statewide system of care expansion process.

HAWAII

Children's Mental Health System

Hawaii, located 2,300 miles southwest of San Francisco, CA, is a chain of islets and eight main islands—Hawaii, Kahoolawe, Maui, Lanai, Molokai, Oahu, Kauai, and Niihau. The population is diverse; more ethnic and cultural groups are represented in Hawaii than in any other state. The state's island geography and its diverse population and numerous cultures and languages present significant challenges to service delivery.

Demographics

As of the 2010 census, the state's population is approximately 1.36 million, with about 70 percent–75 percent living on Oahu, 22.4 percent of the population is under age 18. According to the census data, 24.7 percent of the population is White, 1.6 percent Black, 0.3 percent American Indian/Alaska Native, 38.6 percent Asian, 10 percent Native Hawaiian and Other Pacific Islander, and 20 percent two or more races. Persons of Hispanic or Latino origin comprise 8.9 percent of the population across all races. Nearly 27 percent of households reported speaking a language other than English at home.

Hawaii has a highly centralized government. Its children's mental health system is administered by the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health, and its three counties have no role in financing the system or delivering services. Through an agreement with the state's Medicaid agency, CAMHD operates a carve-out that serves youth with emotional and behavioral disorders. Under the CAMHD structure are seven public Family Guidance Centers (community mental health centers) located throughout the state that are responsible for mental health service delivery to children, adolescents, and their families. The centers provide care coordination, assessment, and outpatient services and arrange for additional services with contracted provider agencies.

Overall Strategy

As a result of a lawsuit filed in 1993, Hawaii entered into the Felix Consent Decree in 1994 in which it agreed to expand and improve services statewide. A detailed implementation plan established the goal of creating a statewide system of care that provides a comprehensive array of services and integrates the activities of child-serving agencies. This was the impetus for the statewide expansion of the system of care approach.

During the time of the lawsuit, Hawaii built upon a foundation of system of care values, dating back to its CASSP grant. The state has expanded its range of services, provided more home- and community-based services, strengthened the statewide family organization (Hawaii Families as Allies), created strong child and family teams, established an accountability system with considerable transparency, built partnerships with the University of Hawaii, and promoted evidence-based practices as a complement to individualized care. Court supervision for the consent decree ended in 2005, resulting in less money for direct services. As a consequence, there have been some cutbacks in services and in the number of children being served; however, system of care values remain strong, which is most evident in care coordination efforts, the individualized approach with child and family teams, and the work of families. Currently, there are efforts to improve coordination across service sectors and a major push toward electronic health records.

Strategic Use of Grants

Hawaii System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Hawai'i 'Ohana Project, Wai'anae Coast and Leeward, Oahu	1994
Project Ho'omohala, Honolulu	2005
Project Kealahou—A New Pathway for Girls, Honolulu County	2009

Hawaii had two active federal system of care grants at the time of the study. The activities were focused on improving services for two important populations—transition-age youth and adolescent girls in the juvenile justice system who have experienced trauma. The state previously had one other system of care grant serving several islands, with limited impact. The primary impetus for promoting systems of care was the class-action lawsuit. The earlier CASSP grant led to a strong commitment to system of care values and principles.

MAINE

Children's Mental Health System

Maine is a state-oriented system, with children's mental health services administered by the Division of Children's Behavioral Health Services (CBHS) in the Maine Department of Health and Human Services. The state is divided into three regions.

Demographics

Maine's population is estimated at approximately 1.33 million based on the 2010 census; 20.6 percent is under age 18. The state's racial and ethnic makeup is 95.2 percent White, 1.2 percent Black or African–American, 0.6 percent American Indian/Alaska Native, 1 percent Asian, and 1.6 percent two or more races. About 1.3 percent is of Hispanic or Latino origin across all races.

Overall Strategy

Maine has been promoting the system of care approach since it first received a CASSP grant in the mid-1980s. Since then, progress toward statewide implementation has been steady. Maine has used several major expansion strategies:

- Establishing a local infrastructure
- Extensively using Medicaid and Mental Health Block Grant funds

- Requiring adherence to system of care principles in contracts
- Building strong youth and family organizations
- Implementing the wraparound process
- Focusing on trauma
- Implementing evidence-based practices
- Using data to make the case for expansion
- Providing training and TA

Maine is currently on its third system of care grant, entitled Thrive, which serves 3 of 16 counties and has played a significant role in expansion efforts. A local infrastructure for system of care management was created in each of Maine's regions in the form of community collaboratives with regional leaders who are state employees and families and youth. Medicaid is used extensively to finance services and covers a broad array of services and supports. In 2009, Maine instituted a requirement that all providers who contract with CBHS implement the system of care philosophy and approach and that they conduct self-assessments of their progress. The state is developing a monitoring and continuous quality improvement system.

Approximately 50 percent of Maine's Mental Health Block Grant funds are allocated to children, including youth and family organizations. A strong youth organization was developed with the support of a special $100,000 budget supplement in Year 3 of the Thrive system of care grant; the youth organization is now active in 14 of the state's 16 counties. There have been numerous family organizations, but Thrive has brought them together to create a statewide family organization.

In partnership with the child welfare system, Maine has implemented Wraparound Maine, with nine high-fidelity wraparound sites that serve children in the child welfare system who have intensive service needs. Through these services, the state has successfully reduced the use of residential care.

Another strategy has focused on implementing evidence-based practices. Although there has been some focus on Multisystemic Therapy and Functional Family Therapy, a considerable investment has been made in the implementation of trauma-focused care. Evidence-based interventions, such as Trauma-Focused Cognitive Behavior Therapy, are widely used and disseminated throughout the state. Maine has been a leader in emphasizing the need for trauma-focused systems and services. In addition, data from the Child and Adolescent Functional Assessment Scale (CAFAS) are used to promote statewide system of care expansion. Although Thrive provides direct services in only three counties, it provides statewide training and TA and plays a leadership role in statewide expansion efforts.

Strategic Use of Grants

Maine System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Wings for Children and Families, Piscataquis, Hancock, Penobscot, and Washington Counties	1994
Kmihqitahasultipon ("We Remember") Project, Passamaquoddy Tribe Indian Township	1997
Thrive: A Trauma-Informed System of Care for Children With Serious Emotional Disturbance in Maine, Androscoggin, Franklin, and Oxford Counties	2005

Thrive is Maine's third system of care grant, and plays a major role in expansion by providing leadership, developing family and youth organizations, and providing training and TA. Earlier grants covered two counties and two tribal communities. These grants have served as models for change elsewhere in the state and influenced policy development, particularly with regard to Medicaid.

MARYLAND

Children's Mental Health System

The children's mental health system in Maryland is administered by the Office of Child and Adolescent Services of the Mental Hygiene Administration within the Maryland Department of Health and Mental Hygiene. Policy-level leadership is provided by a Children's Cabinet in the governor's office, which comprises the directors of child-serving systems. Local Management Boards (LMBs) provide leadership for systems of care at the local level, and Core Service Agencies are responsible for local oversight of the public mental health system.

Demographics

Maryland has a population of approximately 5.8 million people divided among 23 counties and Baltimore city. About 24 percent of the population is under age18. Most of the population lives in the state's central region, in the Baltimore Metropolitan Area. Census data from 2010 show that the population is 58.2 percent White, 29.4 percent Black or African–American, 5.5 percent Asian, 2.9 percent two or more races, and 0.01 percent American Indian/Alaska Native. Approximately 8.2 percent of the population is of Hispanic origin across all races.

Overall Strategy

Before implementing its system of care, Maryland had a history of reliance on residential treatment in general and out-of-state placements in particular. To address this and other systemic issues, Maryland began to focus on developing systems of care. The state had one of the first system of care grants in Baltimore City, awarded in 1993, that placed children's mental health social workers in the Baltimore City Schools; a subsequent grant was obtained for Montgomery County in 1999. Maryland's expansion efforts have benefitted from a Children's Cabinet, created by the governor in 1987 via executive order and established by statute in 1993 to improve the structure and organization of services to children, youth, and families. In addition, the Governor's Office for Children (GOC) coordinates child- and family-oriented care within the state's child-serving agencies; the executive director of the GOC chairs the cabinet.

A critical juncture in statewide development of systems of care began in 2002, when the need for the wraparound approach for children with serious mental health challenges was recognized at

the gubernatorial level. The state pursued the implementation of the wraparound approach (piloted in the system of care grants) and community-based services directed at decreasing the use of institutions and providing alternatives to high-cost services with poor outcomes. The convergence of high-level support with the experience of the system of care grants led to the statewide system of care development initiative. In 2005, the Children's Cabinet provided $1 million to Montgomery County, $ 1 million to Baltimore, and smaller amounts to other areas to pilot the care management entity (CME) model, community-based care, and wraparound.

Maryland has consistently looked for opportunities to obtain financing to support its efforts to expand the system of care approach. A 1915(c) Medicaid waiver and pooled funds across systems at the Children's Cabinet level have helped to expand service capacity statewide.

Maryland has a strong family organization that preceded the system of care grants, and more recently a chapter of Youth M.O.V.E. has been developed. The state has used a number of strategies:

- Developing CMEs that cover the entire state and a statewide administrative services organization (ASO), both based on the system of care approach
- Placing strong emphasis on high-fidelity wraparound
- Creating highly effective interagency partnerships through the GOC, whose executive director chairs the Children's Cabinet
- Establishing the Innovations Institute at the University of Maryland as a statewide training and TA center

Maryland has had stable leadership in the children's mental health area. The state has been very successful in receiving system of care grants and other federal grants that have provided resources for system change and have been used to guide stakeholders toward a system of care vision. In what one of the key informants described as an "opportunistic" approach, Maryland has seized opportunities to apply for grants, Medicaid waivers, and other vehicles to further its expansion efforts.

Leaders in Maryland have focused on educating people about systems of care and reaching out to influential individuals and high-level decision makers to get them on board. In addition, the state has been systematically gathering data to support systems of care. For example, the number of children and youth in out-of-state residential programs was significantly reduced. The data describing these types of positive outcomes have been presented to leaders in the legislative and executive branches. The combination of the collection and use of data, the efforts of family and youth advocates, and the interagency leadership has been very powerful in advancing systems of care.

The system has survived the transition in administrations between parties and the recession and resulting fiscal crisis. The incorporation of the approach into state policy and the outreach to high-level policy makers are seen as keys to progress, particularly the existence of the Children's Cabinet and an interagency strategic plan for improving services to at-risk children, youth, and families.

Strategic Use of Grants

Maryland System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
East Baltimore Mental Health Partnership, East Baltimore	1993
Community Kids, Montgomery County	1999
MD CARES (Maryland Crisis and At Risk for Escalation Diversion Services), Baltimore City	2008
RURAL Crisis and At Risk for Escalation Diversion Services (CARES), Caroline, Cecil, Dorchester, Kent, Queen Anne's Somerset, Talbot, Wicomico, and Worcester Counties	2009

In 1993, Maryland was one of the first four states to receive a SAMHSA system of care grant. The grant was focused on the East Baltimore neighborhood and had a particular emphasis on school-based services. Subsequently, the state received three additional system of care grants.

The requirement of SAMHSA that the local system of care grants tie in with the state was seen as an opportunity to begin a process for statewide system of care expansion. For example, pilots of CMEs and the wraparound approach in Baltimore City and Montgomery County were then built into the statewide system development effort. The more recent grants are now assisting with system of care expansion, particularly in rural areas. The interviewees emphasized the importance of the federal CMHI grants in leveraging other, long-term funding sources for the system of care approach.

MICHIGAN

Children's Mental Health System

Michigan's state mental health authority resides within the Michigan Department of Community Health, which also has responsibility for Medicaid, public health, substance use, and aging services. With the goal of better coordinating both funds and services, Michigan created a managed care system through which it contracts with 18 Prepaid Inpatient Health Plans (PIHPs) for Medicaid Specialty Services and Supports. The PIHPs comprise 46 community mental health service programs (CMHSPs) as health plans to serve the state's 83 counties. A PIHP can be either a single CMHSP or a lead agency in an affiliation of CMHSPs. The PIHPs essentially serve as managed care entities and are responsible for planning and implementing Medicaid-funded services for children with serious emotional disturbance. CMHSPs also administer state general funds for mental health services and provide services to children and youth without Medicaid. Michigan has a 1915(c) Medicaid fee-for-service waiver for children with a serious emotional disturbance.

Demographics

Michigan is the eighth most populous state in the United States and is divided into 83 counties. As of 2010, its population was about 9.9 million, with 23.6 percent under age 18. The census reported that the population was 78.9 percent White, 14.2 percent Black or African–American, 0.6 percent American Indian/Alaska Native, 2.4 percent Asian, 0.2 percent Native Hawaiian or Other Pacific Islander, and 2.3 percent two or more races. Hispanics or Latinos of any race accounted for 4.4 percent of the population.

Overall Strategy

The current strategy for system of care expansion in Michigan is to require each CMHSP to plan for system of care implementation and involve other child-serving system partners. As part of the policy guidelines issued by the state's Department of Community Health, Behavioral Health, and Developmental Disabilities, as well as the department's strategic plan, CMHSPs are required to develop and implement a formal plan, including expectations, specific objectives, and performance targets. In accordance with these requirements, all communities in Michigan are planning for system of care implementation, although some are further along than others.

A new strategy for expansion, in partnership with the child welfare system, has been implemented as a result of a lawsuit, known as Dwayne B. v. Granholm, filed in 2006 on behalf of children in the child welfare system. Among other requirements, the settlement agreement requires improved access to mental health services for the child welfare population. In response, Michigan made the strategic decision to capitalize on federal training and TA related to systems of care. For example, a team of child welfare and mental health leaders (including the mental health commissioner and lead administrator of child welfare) attended a federal system of care conference (the 2008 System of Care Training Institutes). This provided an opportunity for leadership to understand and commit to the system of care approach. A pilot is now under way in eight urban counties for children with serious emotional disturbance utilizing the 1915(c) waiver. Five of the eight pilot counties are either current or former grantees of the CMHI, and three are engaged in system of care development as a result of state policy. The approach will ultimately be expanded statewide. The expansion process remains a priority even in an environment of budget cuts.

Michigan's primary strategies include:

- Using multiple Medicaid waivers and requiring the system of care approach within waivers
- Expanding the service array (primarily under Medicaid)
- Requiring local planning for system of care implementation and providing federal Mental Health Block Grant dollars to support local system of care planning
- Requiring the system of care approach in requests for proposals (RFPs) and contracts with managed care organizations, community mental health service agencies, and providers
- Implementing evidence-based practices
- Implementing an outcome measurement system statewide
- Implementing a partnership with the child welfare system to expand resources and the population served with system of care approach

Strategic Use of Grants

Michigan System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Southwest Community Partnership, Detroit	1997
Mno Bmaadzid Endaad ("Be in good health at his house"), Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Ojibwa Indian Community; Chippewa, Mackinac, and Schoolcraft Counties	1998
Impact, Ingham County	2005
Kalamazoo Wraps, Kalamazoo County	2005
Community Family Partnership (CFP), Kent County	2009
Saginaw System of Care, Saginaw County	2010

Michigan has had a total of six system of care grants, with Ingham and Kalamazoo Counties nearing the end of their funding cycles and two relatively new federally funded communities. These sites have strategically piloted approaches and brought their expertise into statewide expansion planning. The SAMHSA-funded grantee communities provide training and TA to other counties in the state.

NEW JERSEY

Children's Behavioral Health System

Children's behavioral health services are administered by the Division of Child Behavioral Health Services of the New Jersey Department of Children and Families. The system serves a statewide, total population of children and adolescents with emotional and behavioral disorders who depend on public systems and their families. The system is described as a single, statewide integrated system of behavioral health care across child-serving systems, with the goals of providing a broad array of services; organizing and managing services; and providing care based on system of care values including individualized service planning, family–professional partnerships, culturally competent services, and a strengths-based approach to care.

Demographics

New Jersey has a population of about 8.8 million people as of the 2010 census, with 23.5 percent under age 18. New Jersey is the eleventh most populous (and most densely populated) state in the United States. As of the 2010 census, the racial makeup of New Jersey is 68.6 percent White, 13.7 percent Black or African–American, 0.3 percent Native American Indian/Alaska Native, 8.3 percent Asian, 0 percent Native Hawaiian and Other Pacific Islander, and 2.7 percent two or more races. Across all races, 17.7 percent of the population is Hispanic or Latino. The state has 21 counties.

Overall Strategy

New Jersey was a CASSP grant recipient and received its first and only system of care grant for Burlington County in 1999. Concurrent with its federal grant funding, New Jersey actively developed a statewide effort for system change. Efforts to implement systems of care statewide took a big leap forward with a concept paper developed in 2000 that laid out a plan for statewide system of care development. The plan has involved a systematic effort to roll out system of care development sequentially in each county or in groups of smaller counties comprising a service

area. Implementation was a 5- to 6-year process, with the first three counties rolled out in 2001 and the last three counties rolled out in 2006.

There was a great deal of high-level and political support for this initiative (first referred to as the Children's System of Care Initiative), including from the governor's office. The initiative created much excitement in the state, particularly among families who were instrumental in developing and generating support for the concept paper. Family advocacy is credited as a critical factor in the adoption of the initiative. The statewide implementation of the system of care approach is firmly established in state policy and has spanned multiple administrations.

The systems of care in New Jersey include the following features:

- A community service organization (CSO) in each county to manage care for children with intensive service needs
- Individualized service planning, delivery, and care coordination using child and family teams
- A Family Support Organization is tied to each CSO
- Mobile crisis response available to all children
- Youth case management for children with moderate needs
- A statewide Contracted System Administrator to serve as an administrative services organization to manage referrals, data, financing, and other system-level functions

The statewide system of care implementation has been supported by Medicaid, based on funds pooled across the mental health, child welfare, and Medicaid systems that were leveraged to draw down additional federal monies. New Jersey is no longer in the expansion phase since it has achieved statewide implementation.

Strategic Use of Grants

New Jersey System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Burlington Partnership, Burlington County	1999

As noted, New Jersey's system of care grant in Burlington County was launched only a short time before the statewide expansion was undertaken. From the outset, this grant was not seen as system of care implementation in a single county, but as a basis for launching statewide system of care development. Many of the strategies piloted in Burlington County were adopted for the statewide initiative.

NORTH CAROLINA

Children's Mental Health System

North Carolina's children's mental health system is administered by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the North Carolina Department of Health and Human Services. Mental health providers historically were public employees, but a transition was made several years ago to using private providers. Currently there are Local Management Entities (LMEs) throughout the state that are responsible for system of care management in their respective areas and are required to have family and youth representation. Within the LMEs are critical access behavioral health agencies (CABHAs), which are service providers certified by the state.

Demographics

The 2010 census estimated North Carolina's population at 9.5 million, with 24.3 percent under age 18. The state's racial and ethnic makeup is 68.5 percent White, 21.5 percent Black or African–American, 2.2 percent Asian, 1.3 percent American Indian/Alaska Native; 0.01 percent Native Hawaiian or other Pacific Islander, and 2.2 percent two or more races. Persons of Hispanic or Latino origin comprise 8.4 percent of the population across all races. The state has received considerable numbers of immigrants from Latin America, India, and Southeast Asia. North Carolina is divided into 100 counties.

Overall Strategy

North Carolina has a strong history of involvement in system of care development and has taken advantage of CASSP and multiple system of care grants to support expansion efforts. The development of systems of care was originally spurred by a lawsuit (Willie M.) in 1979 that required youth in the Willie M. class to receive whatever services were needed to keep them in the community. The Willie M. class covered youth with neurological or mental disorders who had aggressive or antisocial behaviors; however, this gave rise to an expanded range of services for all youth with serious mental health challenges, with a particular focus on case management and wraparound.

The major strategies used by North Carolina for statewide system of care expansion include:

- Creating state and local structures for system of care management
- Supporting the development of a strong family organization
- Infusing the system of care approach into all policies and plans
- Providing extensive training on systems of care
- Increasing Medicaid financing for services and supports

The state has created both state- and local-level management structures for systems of care. In addition to the administrative locus of accountability at the state level, there is a strong state-level interagency collaborative for children, youth, and families that promotes and supports statewide system of care development. The collaborative is co-chaired by a parent and a faculty member from the University of North Carolina–Chapel Hill. The state also received funding from the legislature for 35 system of care coordinators, who are part of the LMEs and are responsible for systems of care. Twelve school-based system of care coordinators are also funded by the state.

North Carolina has also supported the development of a strong family organization, North Carolina Families United, and has made genuine progress in providing a strong voice for families. A Youth M.O.V.E. chapter is in the early stages of development.

A significant strategy has been to infuse system of care language into all policy documents, plans, contracts, and other aspects of the service system, including the state plan. Staff of the LMEs and CABHAs are required to receive system of care training. The state has worked closely with five different universities, a system of care grant community in Mecklenburg, and North Carolina Families United to develop curricula and implement training as part of its strategy for statewide expansion.

North Carolina has also modified Medicaid service definitions and added new service options as part of moving to the Medicaid Rehabilitation Option.

Strategic Use of Grants

North Carolina System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Pitt-Edgecombe-Nash Public Academic Liaison Project (PEN-PAL), Pitt, Edgecombe, and Nash Counties	1994
North Carolina Families and Communities Equal Success (FACES), Blue Ridge, Cleveland, Guilford, and Sandhills	1997
Mecklenburg CARES, Mecklenburg County	2005
Alamance Alliance for Children and Families, Alamance County	2008
Building Every Chance Of Making It Now and Grown-Up (BECOMING), Durham County	2010

North Carolina has had a total of five system of care grants, some awarded to the state that focused on multiple counties and others awarded directly to local areas (Alamance County for the 0–5 population and Mecklenburg County, the county with the largest population). All of these grants have been used to provide training and TA; assist in state planning; demonstrate the application of system of care values, principles, and practices; and provide outcome data.

OKLAHOMA

Children's Mental Health System

In Oklahoma, the state mental health system is administered by the Oklahoma Department of Mental Health and Substance Abuse Services. State agency directors are governed by boards rather than being appointed by the governor, and services in counties are funded largely through state agencies. Providers are either state operated or contracted private, non-profit agencies. Community Mental Health Centers serve as the hub for the majority of outpatient services and are also often host sites for other specialized programs. The state has created an interagency team

Demographics

The population of Oklahoma is approximately 3.7 million, with 24.9 percent under age 18. The racial and ethnic makeup of the population is 72.2 percent White, 7.4 percent Black or African–American, 8.6 percent American Indian/Alaska Native, 1.7 percent Asian, 0.1 percent Native Hawaiian or Other Pacific Islander, and 0.1 percent two or more races. About 8.9 percent of the population is of Hispanic or Latino origin across all races. The state is divided into 77 counties and is largely rural.

to coordinate care for children and youth at the highest risk of needing acute or residential treatment. The team works across state agency lines to ensure continuity of care, family choice, and adequate resources. Children, Youth and Family Services' goal is to link children and youth with community-based services through a local system of care in every county. The state is working toward statewide coverage within the next 6 years.

Overall Strategy

Oklahoma applied unsuccessfully for a system of care grant in 1999, but then found resources to pilot systems of care in two counties without federal support. Their first system of care grant, awarded in 2002, went to the state and focused on urban and midsize counties. The state was able to expand to more counties than promised in the grant application due to legislative appropriations. A second grant received in 2008 provided resources to expand systems of care throughout the state. Oklahoma has used system of care grant funds to provide state-level infrastructure and to help fund local coalitions. The state's goal is to have a system of care in each county by 2014.

To support statewide expansion, Oklahoma counties applied for system of care funding through an RFP process. Counties received about $140,000 from the state to support local systems of care. Medicaid has financed the bulk of direct-service costs, including three new Medicaid reimbursement codes for wraparound facilitation, family support providers, and behavioral health aides. Each county was required to have a multisector coalition with parent participation, to use the wraparound process, and to provide care coordination and family support services.

System of care expansion efforts in Oklahoma are aided considerably by strong, highly positive partnerships among the mental health, Medicaid, juvenile justice, and child welfare agencies, which all participate on a state advisory team. In addition, the state provides extensive training and TA and conducts annual site visits to each community for quality assurance purposes. Monthly reports are required from each county, and system of care communities statewide meet every month.

An extensive focus on system of care values and principles and on the wraparound process has been a major component of the state's expansion strategy. Strategic planning has also been a cornerstone of Oklahoma's approach, with each county required to develop a strategic plan. The University of Oklahoma conducts an independent evaluation of system of care implementation, and reports are provided to the Oklahoma Legislature. The state also provides a toolkit with many resource materials to inform county implementation efforts. Local coalitions in each area determine the lead agency for the system of care.

Overall, Oklahoma's strategy has been characterized by strong and united state-level leadership, a focus on local coalitions, quality assurance and evaluation, training and TA, the wraparound process, care coordination, and family voice.

Strategic Use of Grants

Oklahoma System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Choctaw Nation CARES, Choctaw Nation of Oklahoma	2001
Great Plains Systems of Care, Beckham, Canadian, Kay, Oklahoma, and Tulsa Counties	2002
Protecting the Future, Muscogee (Creek) Nation	2008
Oklahoma System of Care Statewide Initiative (OSOCSI), statewide	2008

As noted, the process of preparing a grant application in 1999 spurred interest and resources for system of care pilots, even though federal system of care grant funding was not obtained at that time. Oklahoma ultimately received system of care grants that have been used strategically to establish the infrastructure for systems of care statewide. These grants focus on training and TA, continuous quality improvement, evaluation of progress, and social marketing.

RHODE ISLAND

State Characteristics

Rhode Island, the smallest state in the United States by area, is divided into municipalities, which handle all local government. The children's mental health system is administered by the Division of Community Services and Behavioral Health within the Rhode Island Department of Children and Families (DCF).

Demographics

As of the 2010 census, the population of Rhode Island was approximately 1.05 million, with persons under age 18 accounting for 21.5 percent. The racial and ethnic makeup of the population includes 81.4 percent White, 5.7 percent Black or African–American, 0.6 percent American Indian/Alaska Native, 2.9 percent Asian, 0.1 percent Native Hawaiian or Other Pacific Islander, and 3.3 percent two or more races. Across all races, 12.4 percent are of Hispanic or Latino origin.

Overall Strategy

Rhode Island has a long history of developing systems of care, starting with the federal CASSP grant and extending through several system of care grants. Rhode Island's leadership has built on lessons learned from these initiatives and has systematically determined the policies, legislation, and requirements needed to achieve statewide implementation of the system of care approach.

Rhode Island has used the following major strategies:

- Developing and implementing strategic plans
- Enacting legislation
- Requiring the system of care approach in all policies, plans, standards, and contracts
- Creating a broad array of services and supports
- Implementing the wraparound approach to service delivery
- Providing training
- Increasing the use of Medicaid

The current initiative for statewide system of care implementation began with a legislatively directed task force in 2003 that was charged with creating a strategic plan and blueprint for organizing a system of care for children, youth, and families. Through this process, agreement on the principles for systems of care was achieved at the highest levels. The state has since pursued a strategy establishing systems of care statewide and sequentially including additional target populations. The initial strategy was to focus on the front end by preventing children from coming into DCF care, being hospitalized, or being placed out of home through prevention and early identification. The initial strategy comprises Phase I, which was initiated in 2009. Phase II, begun in 2011, is targeted to children, youth, and families legally under the auspices of DCF and focuses on moving individuals from various deep-end placements to home- and community-based approaches.

Unlike in other states, legislation in Rhode Island has been a system change strategy—including legislation establishing the behavioral health component of DCF that specifies a system of care approach, legislation that required blended funding to support system of care development, and a statute requiring DCF and Medicaid to collaborate. Practice standards (e.g., for wraparound) and contracts with providers all have strong requirements for the system of care approach. The service array has been expanded and the statewide implementation of the wraparound approach has led to individualized care. Training capacity was established at an existing Child Welfare Institute at the Rhode Island College, and the state has worked closely with the Parent Support Network of Rhode Island. A global Medicaid waiver and strong collaboration with the Medicaid agency has resulted in broad coverage, such as Medicaid reimbursement for the wraparound process, early childhood mental health services, evidence-based practices, and a wide range of other services and supports.

Strategic Use of Grants

Rhode Island System of Care Grants From the Federal CMHI	
Grants	**Year of Initial Funding**
Project REACH Rhode Island, statewide	1994
Project Hope, statewide	1998
Rhode Island Positive Educational Partnership (PEP), statewide	2005

Rhode Island has had three system of care grants. Project REACH established the system of care approach statewide and focused on keeping children with serious mental health disorders at home and in the community, developing a family-driven model, and developing a wraparound approach with family service care coordinators and child and family teams. Subsequently, Project Hope focused on the juvenile justice population and the Positive Educational Partnership focused on early childhood and school-based services for children up to age 12, using the wraparound approach as the key intervention method.

The drivers for the current work of statewide system of care implementation were successes from these grants, including data that demonstrated positive outcomes and the effectiveness of the system of care approach. The approaches implemented through these grants have been the basis for the subsequent plans and statewide expansion efforts.

CHAPTER 3: EFFECTIVE STRATEGIES FOR EXPANDING THE SYSTEM OF CARE APPROACH

This chapter presents the findings on strategies used for expanding systems of care. Findings are presented within the strategic framework of five core strategy areas developed for the study that was described earlier.

The study identified the most effective strategies within each area, based on the experience of the nine states included in the sample. Each core area is discussed below. The most effective strategies and those found to be underutilized are described. The study team defined underutilized strategies as those that have the potential to have an impact on system of care expansion but were not used in most states. States have used strategies selectively, choosing those that they considered to be the most appropriate for their particular contexts. In some states, respondents indicated that resource limitations affected their decisions about what strategies to employ. Examples of how each strategy was implemented are included. These findings establish a research base for implementing the high-level systemic changes needed to move toward widespread adoption of the system of care approach and are intended to assist other states in their efforts to expand their systems of care statewide.

In several instances, new strategies to include in the strategic framework were identified through interviews with study informants and through discussions with the advisory panel. Where applicable, those strategies are included in the summary tables.

I. IMPLEMENTING POLICY, ADMINISTRATIVE, AND REGULATORY CHANGES

Making state-level policy and regulatory changes that infuse and institutionalize the system of care philosophy and approach into the larger service system to support expansion of the system of care approach

Table 4 summarizes the findings in this core area.

Table 4. Policy, Administrative, and Regulatory Strategies

Implementing Policy, Administrative, and Regulatory Changes	
Most Effective Strategies	**Underutilized Strategies**
• Establishing an organizational locus of system of care management and accountability at the state and local levels • Developing and implementing strategic plans • Developing interagency structures, agreements, and partnerships for coordination and financing • Promulgating rules, regulations, guidelines, standards, and practice protocols • Incorporating the system of care approach as requirements in RFPs and contracts	• Enacting legislation that supports the system of care approach • Incorporating the system of care approach in protocols to monitor compliance with system of care requirements
New strategies to add to framework based on information generated through the study: • Incorporating the system of care approach into data systems for outcome measurement and quality improvement • Linking with and building on other system change initiatives (health reform, parity legislation, reforms in other systems)	

Most Effective Strategies

Establishing an Ongoing Locus of Management and Accountability for Systems of Care

Creating or assigning a viable, ongoing focal point of management and accountability at the state and local levels (e.g., agency, office, staff) to support expansion of the system of care approach

State Level—In most states in the study sample, a state-level agency has taken the lead for system of care development and has had major responsibility for both policy and for system management and oversight. A number of states have interagency entities serving as policy and leadership bodies; however, those states also have a focal point of management and accountability within an agency that provides consistent and continuous leadership and management for system of care implementation. An example of this dual approach can be seen in Maryland, where the administrative locus of accountability is in the Office of Child and Adolescent Services of the Mental Hygiene Administration, and policy leadership is provided by a Children's Cabinet at the gubernatorial level that comprises executives from child-serving agencies.

Examples: State-Level Locus of Management and Accountability

Arizona:

- The original focal point was a Children's System of Care Network Development structure at the state level. Currently, the focal point is a Children's System of Care Office in the Division of Behavioral Services, Arizona Department of Health Services and Medical Director for Children's Services.

Hawaii:

- Child and Adolescent Mental Health Division of the Hawaii Department of Health is the focal point, with a mission of providing effective mental health services "within a system of care that integrates system of care principles."

Maine:

- The focal point is Children's Behavioral Health Services in the Maine Department of Health and Human Services.

Maryland:

- The administrative locus of accountability is in the Office of Child and Adolescent Services, Mental Hygiene Administration.
- Policy-level management and interagency financing rests within the Children's Cabinet at the gubernatorial level that comprises executives across child-serving agencies.

Michigan:

- The Division of Mental Health Services to Children and Families, Department of Community Health serves as the focal point.
- A team of mental health and child welfare agency staff serves as the focal point of accountability for the widespread implementation of systems of care across those systems.

New Jersey:

- System of care expansion started as the Children's Initiative with an interagency executive board as the state focal point. Subsequently, the Division of Child Behavioral Health Services within the Department of Children and Families was created and manages systems of care statewide, with an interagency committee fulfilling advisory and coordination functions.
- A statewide Contracted Systems Administrator serves as an administrative services organization and manages referrals, data, reporting, and so forth on a statewide basis.

North Carolina:

- A state system of care coordinator within the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Health and Human Services, is responsible for system of care management.
- A state collaborative is responsible for policy and planning.

Oklahoma:

- The focal point is within the Oklahoma Department of Mental Health and Substance Abuse Services.

Rhode Island:

- The Rhode Island Department of Children, Youth, and Families is the focal point, with a behavioral health position for children established by the enabling legislation that created this department.

Local Level—At the local level, focal points of management and accountability for system of care implementation vary. Regional behavioral health entities, cross-system bodies, mental health agencies, and CMEs have all been used as local management structures. For example, regional authorities are responsible in Arizona, cross-system entities are used in Maine, mental health agencies are assigned in Michigan and Hawaii, and CMEs are used in New Jersey and Maryland.

Examples: Local-Level Locus of Management and Accountability

Arizona:
- Regional and Tribal Behavioral Health Authorities are the focal points of accountability for systems of care in each area of the state; they are required to have a staff position focused on children.

Hawaii:
- Family guidance clinics on each of seven islands serve as the focal points of accountability for systems of care. The clinics are state agencies operated by the Hawaii Child and Adolescent Mental Health Division.

Maine:
- Regional collaboratives in three regions covering 16 counties are responsible for system of care implementation.

Maryland:
- Care management entities have been established statewide as the point of management and accountability for systems of care. Currently, there are three CME regions.
- LMBs (interagency entities) previously provided a locus of accountability and management. They are still convened for coordination, but the focal point has shifted to the CMEs.

Michigan:
- Community mental health agencies are the focal points for systems of care and are required by the state to commit to the approach, develop a plan for implementation, and report on progress.
- LMBs with multiple stakeholders provide a structure for cross-system coordination and overall system management.

New Jersey:
- Care Management Organizations (CMOs) in each county are the local focal points. The CMO approach was piloted in the system of care grant community in Burlington County, and lessons learned were used in the process of creating similar structures statewide.

North Carolina:
- Local management entities are the local focal points of accountability for systems of care. Special legislative funding was received for 35 system of care coordinators who are parts of LMEs.

Oklahoma:
- Local coalitions are the focal points for systems of care and are responsible for case and system planning.

Rhode Island:
- Family Care Community Partnerships in each of the state's four regions are responsible for building systems of care based on state-developed implementation standards. Each partnership is a private, nonprofit entity under contract with the state to serve as the lead agency and point of accountability for systems of care and wraparound in each region.

Developing and Implementing Strategic Plans

Developing and implementing strategic plans that establish the system of care philosophy and approach as goals for the state's service delivery system to support expansion of the system of care approach

Most of the states have used a strategic plan, whether formal or informal, to guide their system of care expansion efforts. A formal strategic plan for statewide systems of care was created in response to a class-action settlement in Arizona. Maryland has followed an interagency strategic plan created at the Children's Cabinet level with extensive community and stakeholder input. New Jersey used a concept paper to guide statewide system of care implementation, and Oklahoma has used action plans and logic models.

Examples: Strategic Plans

Arizona:

- A strategic plan for statewide system of care development originated with the settlement agreement of a class-action lawsuit in 2001. The plan specified 12 principles reflecting the system of care philosophy that have guided expansion. An annual plan has broad goals and objectives, and each region is required to develop its own system of care plan in accordance with state-level objectives.

Hawaii:

- The legislature requires a 4-year strategic plan for children's mental health services that is created with input from stakeholders and partner agencies. For each goal, the plan delineates specific initiatives to achieve the goal, benchmarks, deliverable products, units responsible, and due dates. Examples of plan priorities include implementing a comprehensive practice improvement program and a strategic financial plan.

Maine:

- Maine does not use a formal strategic plan but incorporates system of care goals in other plans such as the federal Mental Health Block Grant program.

Maryland:

- An interagency strategic plan was developed at the Children's Cabinet level and is agreed upon across agencies. Action steps are updated quarterly. The plan has been useful in demonstrating to all stakeholders what needs to occur for statewide system of care expansion.

Michigan:

- A strategic plan for system of care expansion is formalized in the Application for Renewal and Recommitment (ARR) required from community mental health agencies that are responsible for children's mental health services under the managed care system's prepaid health plans. Communities are required to respond with their own plans with objectives, targets, and timeframes for systems of care implementation.

New Jersey:

- A detailed concept paper rather than a formal strategic plan guided statewide system of care implementation and was a key factor in providing an agreed-upon vision and goals for the initiative.

North Carolina:

- The state agency does not use a formal strategic plan, although the state collaborative has a strategic plan for system of care expansion.

Oklahoma:

- A formal strategic plan has not been used at the state level, but action plans and logic models have guided statewide system of care expansion. System of care plans are required at the local level.

Rhode Island:

- A strategic plan for system of care development began in 2003 by a legislatively directed task force to "organize an SOC for children, youth, and families," and agreement of system of care principles was achieved at the highest levels of state government. Concept papers with input from communities, providers, and families led to detailed work plans for the two major phases of statewide system of care implementation. Local strategic plans are also mandated.

Strengthening Interagency Collaboration

Cultivating strong interagency relationships and partnerships through interagency structures, interagency agreements that incorporate the system of care approach, and interagency partnerships for coordination and/or financing to support expansion of the system of care approach

Interagency partnerships were seen as a critical strategy for system of care expansion, particularly in instances where such partnerships have led to cross-agency financing of system of

care infrastructure and services. In several states (such as Arizona, North Carolina, and Oklahoma), partnerships with the state Medicaid agency have resulted in coverage for a broader range of services and supports. A partnership between the mental health and child welfare agencies in Michigan has been instrumental in system of care expansion by creating pilots in eight areas, with plans for eventual statewide implementation.

Examples: Interagency Partnerships for Coordination and Financing

Arizona:

- At the state level, formal memoranda of understanding (MOUs) exist among the agencies represented on the Arizona Children's Executive Committee, which comprises high-level executives across child-serving agencies.
- RBHAs are required to have agreements with child welfare and other agencies for implementation of the system of care approach. They are contractually required to develop cross-agency practice protocols that specify how they will work together at the system and service delivery levels.

Hawaii:

- As the class-action lawsuit ended, renewed efforts took place to build partnerships at the state level.
- A partnership with Medicaid created a carve-out operated by the Child and Adolescent Mental Health Division and finances services to children and youth with complex mental health needs.
- A partnership with education led to the creation of a statewide system of school-based mental health services for children and youth with less-serious mental health problems.

Maine:

- Interagency agreements and partnerships have been developed with the child welfare and corrections agencies, with local education authorities, and with family organizations to fund services and promote the development of systems of care.

Maryland:

- The Children's Cabinet is a partnership across agencies at the highest level, which has been crucial for statewide expansion of the system of care approach. Connected to the governor's office, the cabinet comprises agency executives and pools funds across systems to support expansion of the system of care approach.
- The relationship with Medicaid has led to system of care language in Medicaid regulations. The system of care approach serves as the foundation for the Medicaid Psychiatric Rehabilitation Treatment Facility (PRTF) Waiver program.

Michigan:

- An interagency agreement was created with child welfare at the state level, which was under pressure due to a lawsuit to improve access to, adequacy of, and quality of the mental health services provided to its service population. This has resulted in system of care pilots in eight areas that will eventually be implemented statewide. The agreement provided general fund dollars to be used as Medicaid match, thus redirecting funds to home- and community-based services and creating significant resources for system of care expansion.

New Jersey:

- Collaboration is accomplished through an executive oversight group at the state level and through local interagency groups.
- A strong partnership with Medicaid has been crucial for expansion, as the system is based on Medicaid financing. A partnership with child welfare allowed for redirection of funds spent on residential and group home treatment to draw down additional federal revenue, resulting in substantial resources to support systems of care.

Examples: Interagency Partnerships for Coordination and Financing (continued)

North Carolina:

- MOUs have been used among agencies serving as part of the state collaborative for children.
- A partnership with Medicaid resulted in modified service definitions and new service options to provide system of care services.

Oklahoma:

- Interagency partnerships, particularly with Medicaid, have been instrumental for statewide system of care expansion.
- An integrated budgeting process has been developed for legislative funding across health, juvenile, justice, child welfare, Medicaid, education, and rehabilitation systems and the Commission on Children and Youth.

Rhode Island:

- A great deal of work has been done over the past 8 years to solidify interagency relationships as a base for system of care implementation. For example, MOUs have been developed with the Medicaid agency and are considered to be critical for financing the system of care approach.
- Local Family Care Community Partnerships require cross-agency collaboration.

Promulgating Rules, Regulations, Standards, Guidelines, and Practice Protocols

Promulgating rules, regulations, standards, guidelines, or practice protocols that require elements of the system of care philosophy and approach to support expansion of the system of care approach

Instituting requirements for the system of care approach through various mechanisms was identified as an important component of an overall expansion strategy. Rules and regulations have been used as a strategy in some states (e.g., Medicaid rules in Maryland and Oklahoma). Other states have relied more on standards and guidelines to promote expansion, such as practice protocols in Arizona and standards for lead agencies in Rhode Island.

Examples: Rules, Regulations, Standards, Guidelines, and Practice Protocols

Arizona:

- Provider policy manuals and best-practice protocols have been used as strategies to promote system of care expansion; system of care elements are driven down from the state level to the regional authority and to provider levels through these mechanisms. For example, rules and guidelines for direct support services (e.g., in-home, school-based, behavioral coaches, respite, family support) have been used to broaden the array of services and supports aligned with the system of care approach statewide.

Maine:

- All 160 agencies that contract with Children's Behavioral Health Services are required to implement the principles and practices of a trauma-informed system of care.

Maryland:

- Medicaid and mental health regulations exemplify the systems of care approach, as do all policies of the Office of Child and Adolescent Services in the Department of Health and Mental Hygiene.

Michigan:

- State policies have been used to promote system of care expansion. A recent example is a policy on family-driven, youth-guided care that emerged from participation in a policy academy on this subject that was attended by a delegation of high-level policy makers, parents, and youth. This policy will first be used as an advisory across agencies and subsequently will be incorporated into contracts.

Examples: Rules, Regulations, Standards, Guidelines, and Practice Protocols (continued)

New Jersey:

- Strategies have included practice manuals that support the system of care approach. Regulation of system of care principles and practices has been a valuable strategy for holding the system and providers accountable.

North Carolina:

- System of care language is infused into all plans, policies, regulations, and guidelines. For example, local management entities and critical access behavioral health agencies are required to receive system of care training. Medicaid policies and service definitions are aligned with the system of care approach.

Oklahoma:

- The system of care approach has been incorporated into Medicaid requirements and RFPs.

Rhode Island:

- Requirements have been implemented for many of the elements of systems of care and have forced a shift in approaches across the state. Included are requirements for eligibility, timeliness, documentation, family service care coordinators, family support partners, use of flexible funds, and so forth.
- Standards were developed for the Family Care Community Partnerships, wraparound, and other system of care elements.

Incorporating the System of Care Approach in RFPs and Contracts

Incorporating requirements for elements of the system of care philosophy and approach in RFPs and contracts with providers and managed care organizations to support expansion of the system of care approach

Requirements for the various elements of the system of care approach in contracts with providers, lead agencies, and managed care organizations have been used to support expansion efforts. Informants in several states noted that requirements are best used in combination with other strategies, including incentives such as financing and training, to generate commitment to this approach. Contractual requirements have been used effectively to ensure that all system participants are aligned with the system of care approach and with the state's system of care expansion goals. For example, in Maine, providers receiving state funds are required to apply system of care principles. In Michigan, health plans under the managed care system must contractually implement systems of care, and in New Jersey, all contracts have performance requirements related to the system of care philosophy.

Examples: Requirements in RFPs and Contracts

Arizona:

- Contracts with RBHAs and providers require the system of care approach and alignment with the state's system of care goals. These requirements must be demonstrated with performance measures. Contracts have been used as vehicles for promoting system of care expansion.

Maine:

- Any provider receiving funding from the state must apply system of care principles and provide trauma-informed services.

Examples: Requirements in RFPs and Contracts (continued)

Maryland:

- The system of care approach is reflected in RFPs and contracts with the CMEs, LMBs, the statewide ASO, and contracts with Children's Cabinet agencies.

Michigan:

- Contracts with prepaid health plans and community mental health agencies that provide children's mental health services under the state's managed care system require the implementation of systems of care in each area. Contract language with providers is a considered a crucial strategy for expansion.

New Jersey:

- All contracts have performance requirements aligned with system of care values and principles and require provider agencies to have specific goals in relation to these requirements.

Oklahoma:

- The system of care approach is required in RFPs and contracts with local coalitions and their contracts with providers. All contracts with providers build in the system of care philosophy and approach, and the approach is also reflected in Medicaid requirements.

Rhode Island:

- The wraparound approach (with fidelity) is required in contracts. By including this and other system of care elements in contracts, all agencies and providers are clear about the model and expectations for service delivery in the context of the approach.

Underutilized Strategies

Incorporating the System of Care Approach in Monitoring Protocols

Incorporating the system of care philosophy and approach into protocols to monitor compliance with system of care requirements among providers and managed care organizations to support expansion of the system of care approach

The use of monitoring protocols as a mechanism for assessing implementation of system of care requirements was not identified as a frequently used strategy. However, some states found monitoring to be an effective strategy. For example, in New Jersey, site reviews, review of performance data, and auditing have been an important expansion strategy, and data dashboards provide local and statewide information on system of care development. Oklahoma uses annual site visits and monthly reports on system performance to monitor implementation of the system of care approach. Other states were in early stages of developing capabilities in this area.

Examples: Monitoring Protocols

Arizona:

- The state selects areas to monitor that are likely to have the greatest impact on system of care expansion. Specific goals for contractors have been established in such areas as expanding high-need care management and expanding direct support services; these elements are closely monitored.

Hawaii:

- The state has a strong focus on quality assurance; an annual review of all providers includes reviews of services for individual children and families. This process is used to monitor the implementation of the system of care approach at the service delivery level, including measures related to access, least-restrictive setting, individualized service plan, and outcomes.

Examples: Monitoring Protocols (continued)

Maine:

- Use of monitoring as a strategy to advance system of care expansion is in early stages. Work is under way to establish standards that will be translated into monitoring protocols.

Michigan:

- Prepaid health plans and community mental health agencies are required to set objectives and performance targets in areas that they address in their system of care plans. Also, they are required to produce evidence of achievement and to review themselves against these targets in a self-monitoring process.

New Jersey:

- State oversight including site reviews, review of performance data, and auditing has been an important expansion strategy. Data dashboards that provide profiles to assess performance are generated quarterly. The dashboards report on performance at the CMO level. County-level dashboards then are aggregated across the state to assess system of care development.

Oklahoma:

- The state monitors local systems of care, including visiting each site annually with a family member as part of the team. Conducting interviews, reviewing charts, and examining data are included in the process. A particular focus of monitoring is on high-fidelity wraparound. Monitoring is considered a key part of the expansion strategy, as counties are held responsible for system of care implementation.

Rhode Island:

- State staff review implementation in the field and identify areas in need of correction. Reviews of the newly created Family Care Community Partnerships are designed to identify strengths and areas of needed growth in relation to the standards.

Enacting Legislation that Supports the System of Care Approach

Passing legislation that supports the system of care philosophy and approach to support expansion of the system of care approach

Legislation has not been used as an expansion strategy in most of the states studied. An exception is Rhode Island, where several pieces of legislation are seen as instrumental in establishing the basis for statewide expansion of the system of care approach. These have included (a) enabling legislation for the behavioral health component of the Department of Children, Youth and Families that laid out the department's responsibilities and was based on the system of care approach; (b) legislation crafted during the time of CASSP implementation in the state that required blended funding to support system of care development; and (c) legislation that required the Department of Children, Youth, and Families and Medicaid to collaborate and undertake joint planning. Legislation in Rhode Island has been highly effective in creating the foundation for expanding the system of care approach. In Maryland, legislation was passed in 2011 to remove identified barriers to family-driven care and to align the state's service delivery system with the system of care approach set forth in its interagency strategic plan. Several informants in other states indicated that legislation (similar to other types of requirements) would be helpful in lending "weightiness" to expansion goals.

II. DEVELOPING OR EXPANDING SERVICES AND SUPPORTS BASED ON THE SYSTEM OF CARE PHILOSOPHY AND APPROACH

Implementing the systemic changes needed to develop and expand a broad array of home- and community-based services and supports that are individualized, coordinated, family driven, youth guided, and culturally and linguistically competent to support expansion of the system of care approach

Table 5 summarizes the findings in this core strategy area.

Table 5. Services and Supports

Creating or Expanding Services and Supports Based on the System of Care Philosophy and Approach	
Most Effective Strategies	**Underutilized Strategies**
• Creating or expanding the array of home- and community-based services and supports • Creating or expanding an individualized, wraparound approach to service delivery • Creating or expanding CMEs • Creating or expanding care coordination • Implementing family-driven, youth-guided services and expanding family and youth involvement at the service delivery level	• Creating, expanding, or changing the provider network • Creating or expanding the use of evidence-informed, promising practices, and practice-based evidence approaches • Improving the cultural and linguistic competence of services • Reducing racial, ethnic, and geographic disparities in service delivery
New strategies to add to framework based on information generated through the study: • Implementing or expanding the use of technology (e.g., electronic medical records, telemedicine, videoconferencing, e-therapy)	

Most Effective Strategies

Creating or Expanding a Broad Array of Services and Supports

Creating or expanding a broad range of home- and community-based services and supports that are consistent with the system of care philosophy and approach to improve outcomes to support expansion of the system of care approach

All of the states have broadened their service array to offer a comprehensive range of home- and community-based services and supports, which is an inherent characteristic of systems of care. Expanded coverage under Medicaid has been a primary vehicle for accomplishing this goal. New services and supports include respite, family and youth peer support, intensive care management, intensive home-based services, therapeutic behavioral aide services, skills training, therapeutic foster care, mobile crisis services, crisis stabilization, specific evidence-based practices, and mentoring.

Examples: Broad Array of Services and Supports

Arizona:

- The state's focus has been on expanding the availability and utilization of a broader range of services. The range of services covered under Medicaid was significantly increased by using the capitation rate in the managed care system. The expanded array now includes direct support and rehabilitation services such as respite, family and peer support, skills training, and so forth.

Hawaii:

- The array of services and supports has been expanded to include emergency crisis intervention services; intensive care coordination/clinical case management; intensive home- and community-based treatment interventions; community-based treatment services (therapeutic foster care, therapeutic group homes, community and hospital-based residential); respite and peer support; and several evidence-based interventions.

Maine:

- A broad array of home- and community-based services has been made available statewide, including care management, Trauma-Focused Cognitive Behavior Therapy, family partners, outreach to homeless youth, and life skills classes.

Maryland:

- As a primary strategy for system of care expansion, a full array of home- and community-based services were incorporated into Medicaid, including in-home services, respite, expressive services, crisis response and stabilization, family and youth training, and peer support.

Michigan:

- An extensive array of services has been incorporated in Medicaid including home-based services, respite, peer-to-peer support by parent support partners, community living supports (e.g., aides), infant mental health services, therapeutic foster care, crisis response services, and therapeutic camps, as well as the wraparound process.

New Jersey:

- The service array has been expanded to include mobile crisis response teams, intensive in-home services, therapeutic and behavioral supports, therapeutic foster care, mentoring, family support, flexible funds to supplement the service array based on individual needs, among other services. This expansion has been accomplished by drawing down additional Medicaid funds and has been an integral part of the state's expansion strategy.

North Carolina:

- The state created a broader range of home- and community-based services beyond traditional mental health services established under the label of "community support services" (e.g., peer-to-peer support).

Oklahoma:

- A strong focus on the wraparound process has resulted in expansion of that approach statewide. Other services added to the service array include respite, family support services, mobile crisis services, Trauma-Focused Cognitive Behavior Therapy, and Parent-Child Interaction Therapy.

Rhode Island:

- The service array has been expanded by adding family support, home-based services, parenting skills training, parent aides, mentoring, respite, family service care coordinators, and family support partners; flexible funds for supports not covered otherwise; the wraparound service planning and delivery process; and evidence-informed practices such as Multisystemic Therapy, Functional Family Therapy, and Cognitive Behavior Therapy.

Creating or Expanding Individualized Approach to Service Delivery

Creating or expanding an individualized, wraparound approach to service planning and delivery to support expansion of the system of care approach

An individualized or wraparound approach to service planning and delivery has been a central component of the expansion efforts in all of the states; it has been the primary mechanism for operationalizing the system of care approach at the service delivery level. Most of the states require child and family teams for youth with the most serious and complex service needs, with full family and youth involvement, individualized service plans, care coordination, and flexible funds available to purchase services and supports not covered by other funding sources. Extensive training in the wraparound approach is provided in many states. Wraparound fidelity is often measured using tools from the National Wraparound Initiative, which is a consortium of individuals and organizations seeking to promote high-fidelity wraparound implementation and evaluation (www.nwi.pdx.edu).

Examples: Individualized Approach to Service Delivery

Arizona:

- The wraparound approach is considered to be the basis for the entire system and for implementing the system of care approach at the service delivery level. A child and family team is required for all children on Medicaid. The process is individualized; it may include just the parent, child, and a therapist or psychiatrist for children with less complex needs or a more extensive child and family team process for youth with complex, multisystem needs.

Hawaii:

- Child and family teams are organized as part of the process to develop a coordinated service plan, which is an overarching plan to coordinate all services and supports for an individual child and family. Mental health care coordinators at each family guidance center manage this process, which is Medicaid billable under a code for treatment planning.
- Flexible funds are available to child and family teams to finance services and supports not covered by other sources.

Maine:

- Wraparound Maine was implemented to establish the wraparound process for planning and delivering services statewide as a collaboration between the child welfare and mental health systems. Wraparound Maine serves the child-welfare youth with the highest needs and their families.

Maryland:

- The CMEs use the wraparound process as the primary approach for planning, delivering, and coordinating services, thereby establishing the individualized service approach statewide. The use of the Wraparound Fidelity Assessment System forms the foundation for the standards that govern these entities, along with the training in the Wraparound Practitioner Certificate Program.

Michigan:

- The wraparound process is covered under Medicaid and has been a critical building block for system of care expansion. The process embodies system of care principles at the service delivery level and has been implemented in partnership with child welfare, juvenile justice, education, families, and so forth. The state is measuring wraparound fidelity.

New Jersey:

- The CMOs use the wraparound approach with child and family teams for planning and delivering services.

Examples: Individualized Approach to Service Delivery (continued)

North Carolina:

- The state was one of the first to implement the wraparound approach to service planning and delivery and has worked to expand the use of child and family teams.

Oklahoma:

- The wraparound process is a major part of the state's strategy for expanding the system of care approach for high-need, high-cost youth.

Rhode Island:

- The wraparound process with child and family teams was established statewide and has shifted service delivery to an individualized approach. Extensive training has been provided to support the adoption of this approach.

Creating or Expanding CMEs and Care Management Services

Creating or expanding CMEs to serve as the focal point of accountability and responsibility for managing the services, costs, and care management for children with intensive service needs and their families and creating or expanding care management and coordination services to support expansion of the system of care approach

A number of the states have created CMEs with responsibility for managing service delivery and costs for children with the most serious and complex disorders. Examples include Arizona's RBHAs, New Jersey's CMOs in each county, and Maryland's CMEs that now cover the entire state. These CMEs are an important expansion strategy and a significant service-system innovation.

In addition, some of the states have expanded intensive care management services, such as Arizona's high-need care management services and Maine's extensive use of targeted case management.

Examples: Care Management Entities and Care Management Services

Arizona:

- RBHAs serve as CMEs in each region.
- The state is expanding case management for high-need youth by increased dollars in the capitation rate targeted at hiring more case managers. The regional authorities are required to assign children to high-need case management based on the Child and Adolescent Service Intensity tool and training.

Hawaii:

- State-operated family guidance centers on each island serve as CMEs. At each center, mental health care coordinators who are state employees are responsible for the individualized service planning and delivery process and for coordinating services across agencies.

Maine:

- The state is using two levels of care management. Level 1 involves provision of family support and assistance. Level 2 is intended for children, youth, and families with more serious needs and involves development, implementation, and monitoring of treatment plans.

Examples: Care Management Entities and Care Management Services (continued)

Maryland:

- Maryland currently covers the entire state with three CMEs that provide care coordination using a wraparound practice model to multiple populations of youth with intensive service needs.
- Local entities, LMBs, and core service agencies, have a role in coordinating services for children with complex needs in partnership with the CMEs.

Michigan:

- Prepaid health plans in each area serve as CMEs and they, in turn, contract with community mental health agencies that provide services. The wraparound process is the central approach for service planning and delivery and has expanded care management statewide.

New Jersey:

- Care Management Organizations have been created in every county with responsibility for systems of care and for managing and coordinating care for children with intensive service needs.

North Carolina:

- Local management entities have been established throughout the state as CMEs; within them, critical access behavioral health agencies provide services. These entities, which are in early developmental stages, are expanding care coordination and management.

Oklahoma:

- Care coordination has been expanded through the wraparound approach. In addition, care management supported by Medicaid has resulted in expansion of care coordination.

Rhode Island:

- Though not referred to as care management, the state uses the wraparound process with child and family teams to plan and deliver services. Family service care coordinators serve as facilitators of the wraparound process. By adopting this approach statewide, care coordination has been expanded. Family Care Community Partnerships in each area serve as CMEs.

Implementing Family-Driven, Youth-Guided Services and Expanding Family and Youth Involvement in Service Delivery

Implementing family-driven, youth-guided services and expanding family and youth involvement in the planning and delivery of their own services to improve outcomes to support expansion of the system of care approach

The states view the expansion of family and youth involvement at the service delivery level as a basic tenet of systems of care, with the core value of family-driven and youth-guided services. Family and youth involvement is also a fundamental principle of the wraparound approach and is considered an important strategy for supporting system of care expansion. Some states, such as Arizona, require family and youth involvement in contracts with RBHAs and providers. Nearly all states have family support partners who help families to navigate service systems and provide peer support. In some instances, peer support is funded through a contract with a family organization. In New Jersey, a Family Support Organization is tied to each CMO and facilitates family engagement and involvement in services through peer-to-peer support provided by parent partners. Each of these also houses a Youth Partnership.

Examples: Family and Youth Involvement in Service Delivery

Arizona:

- The state contracts with a family-run organization with one of the objectives being to increase the frequency and quality of family involvement at the service delivery level. The first goal of the state's system of care plan is to expand family and youth roles in services; family and youth involvement is a basic tenet of the wraparound approach.
- Family and youth involvement in services is supported by language in contracts with RBHAs and with providers, as well as in a family involvement protocol and a practice protocol. The family-driven, youth-guided practice protocol was developed as a result of participation in a policy academy on this subject.
- Family members can now be certified as providers under Medicaid (e.g., to serve as family support partners) through a new category of provider agency, community service agency.

Hawaii:

- Through a contract with the state family organization, parent partners are funded to serve as peer advocates and to provide assistance and support to family members. They are tied to each family guidance center and facilitate family involvement in service delivery.

Maine:

- The wraparound process with child and family teams ensures strong family and youth involvement in service delivery.
- Family support partners facilitate and support families in becoming involved in service delivery and are funded through Medicaid.
- Support groups are offered for both family members and youth.

Maryland:

- Families and youth are the drivers of the wraparound process, with child and family teams to plan, deliver, and coordinate services. Families participate in and sign the care plans developed through the CMEs, and the state "preaches, teaches, and coaches" that families and youth must be at the table.
- Family navigators are available through Children's Cabinet funding to LBSs.
- Peer-to-peer support for families and youth peer support were incorporated into the state's Psychiatric Residential Treatment Facility Medicaid waiver.

Michigan:

- The state has implemented a policy on family-driven, youth-guided services based on their work at a policy academy. This technical advisory establishes this as a practice across systems.
- The wraparound process is family driven and youth guided by definition.
- The use of parent partners supports and facilitates family and youth involvement in services by mentoring them, and this is now a covered service under Medicaid.
- The state contracts with the state Federation of Families for Children's Mental Health (FFCMH) chapter through a contract supported with Mental Health Block Grant funds that includes family advocacy positions and a youth leadership council that promote and support family and youth involvement in services. A contract with another family organization funds the delivery of training for parent support partners to work in community mental health agencies.

New Jersey:

- The state has created advisory documents for CMOs and providers regarding family and youth involvement in service delivery. In addition, the wraparound approach is inherently family driven and youth guided.
- A Family Support Organization is tied to each CMO that facilitates family engagement and involvement in services through peer-to-peer support provided by parent partners (as well as fulfilling system-level involvement functions).
- Each Family Support Organization houses a youth partnership.

Examples: Family and Youth Involvement in Service Delivery (continued)

North Carolina:

- The state has added peer-to-peer support as a vehicle for expanding family and youth involvement in service delivery.

Oklahoma:

- Family support partners are supported by Medicaid and have created a mechanism to assist families in having the information they need to participate in service planning as full partners. A state coordinator organizes the assistance and provides training for communities about family-driven services.
- There also are efforts to increase youth involvement in their own services.

Rhode Island:

- The wraparound process is inherently family driven and youth guided, using child and family teams to plan and deliver services with families and youth as full partners. The process involves implementing the strengths, needs, and cultural discovery process, using the family's vision and priorities as the basis for services.
- Family support partners are required through the state's contracts with the Family Care Community Partnerships.

Underutilized Strategies

Creating or Expanding the Use of Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches

Creating or expanding the use of evidence-informed and promising practices and practice-based evidence approaches within systems of care that improve outcomes to support expansion of the system of care approach

A number of states are supporting the implementation of evidence-informed practices, such as Trauma-Focused Cognitive Behavior Therapy in Maine and Parent Management Training–Oregon Model in Michigan. Others are implementing or exploring the common elements approach that identifies practice components across evidence-based interventions and provides training to clinicians in using these approaches. Other than in Maine, however, the states did not identify implementation of evidence-informed practices as a specific expansion strategy.

Examples: Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches

Arizona:

- The use of evidence-informed practices is required through contracts. Practice protocols have been developed for the early childhood population and for adolescent substance use and other interventions. The state promotes but does not require the use of evidence-informed treatment.

Hawaii:

- The state has worked with the University of Hawaii on evidence-informed practices and has an ongoing task force focused on expanding these practices statewide to improve outcomes. Extensive work has been completed to identify the practice components, or elements that comprise clinical approaches, that are supported by research evidence with accompanying training and TA for providers, primarily through state-employed practice development specialists. Various evidence-based practices also have been added to the state's Medicaid plan, such as Multisystemic Therapy, Functional Family Therapy, Parent Skills Training, and Multidimensional Treatment Foster Care.

Examples: Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches (continued)

Maine:

- Expanding the use of evidence-informed practices has been a primary strategy for system of care expansion, and the state has implemented treatments related to trauma for children and youth at different developmental stages. Also, Multisystemic Therapy, Functional Family Therapy, and a form of Assertive Community Treatment specifically developed for youth are offered. There are enhanced payment rates for some of these interventions.

Maryland:

- The state is exploring the use of the common elements approach to implementing evidence-informed practices and continues to implement selected evidence-based practices such as Multisystemic Therapy, Trauma-Focused Cognitive Behavior Therapy, Functional Family Therapy, and Multidimensional Treatment Foster Care.
- The Children's Cabinet has funded the Innovations Institute at the University of Maryland to be the hub of implementation, training, and data collection on evidence-based services statewide, including serving as an intermediate purveyor for specific evidence-based practices.

Michigan:

- The state has supported the widespread implementation of Parent Management Training–Oregon Model and has financed the infrastructure for this practice statewide. This approach is family driven and supports service delivery consistent with the system of care approach. The state is also working on implementing Trauma-Focused Cognitive Behavior Therapy and is moving to develop statewide capacity for this service in all community mental health agencies.

New Jersey:

- This is done locally but is not used as an expansion strategy statewide.

North Carolina:

- The state has supported the implementation of evidence-informed practices including Multisystemic Therapy, Trauma-Focused Cognitive Behavior Therapy, and Motivational Interviewing, and has supported the development of critical access behavior health agencies to promote high-quality, evidence-informed interventions.

Oklahoma:

- The state has invested in the expansion of Trauma-Focused Cognitive Behavior Therapy and is exploring the potential of using an approach of incorporating key elements of evidence-informed services. The main focus has been on the implementation of wraparound.

Rhode Island:

- The state has supported the widespread implementation of Multisystemic Therapy, Functional Family Therapy, Cognitive Behavior Therapy, wraparound, and others. To support start-up costs, the state has allowed providers to build this into their rate for the first year and then drop rates after initial implementation costs are met.

Creating, Expanding, or Changing the Provider Network

Creating, expanding, or changing the provider network by adding new types of home- and community-based providers and changing licensing and certification to support expansion of the system of care approach

Although expanding the provider network for the expanded array of services and supports is an underutilized strategy, several states have found it to be an effective strategy. Arizona, for example, added a new type of provider agency for direct support and rehabilitation services, and Rhode Island expanded the provider network beyond community mental health centers through its newly created Family Care Community Partnerships. Others states have expanded their

networks by adding providers for new services such as respite, mentoring, therapeutic behavioral aide services, and others.

Examples: Provider Network

Arizona:

- A new provider type, community service agency, was created to expand the provider network. This allows agencies to expand services to include direct support and rehabilitative services, specialty providers (e.g., for the population ages 0–5 and for co-occurring mental health disorders and developmental disabilities, trauma, and sexual problems), family support partners, and others. This was piloted in one county and then expanded statewide. The addition of new providers beyond traditional providers has brought expertise in home- and community-based services to the system.

Hawaii:

- The state has created a broad array of providers including nontraditional providers (such as Native Hawaiian healers) through Medicaid and other resources, although a broad array of providers is more challenging on the smaller islands.

Maine:

- The state has created a certification process for Trauma-Focused Cognitive Behavior Therapy and also for Child-Parent Psychotherapy.
- A variety of mechanisms, including job fairs, has been used to expand the provider network.

Maryland

- The state is an any willing provider state; therefore, it includes in its network any provider willing to provide services under Medicaid so long as the standards for the service are met. Under the Medicaid waiver, new types of providers beyond traditional providers are now included to provide the expanded array of home- and community-based services, such as providers for family-to-family peer support, crisis response and stabilization, respite, and various types of expressive therapies (e.g., art, music, dance).
- The CMEs work with care coordinators and the community to identify unmet needs and to identify potential resources and providers to fill gaps.

Michigan:

- The state has allowed community mental health agencies the flexibility to add providers to their networks to deliver covered services such as community living supports, respite, parent partners, and others.

New Jersey:

- The state recruited new providers to expand the base beyond community mental health centers and create the capacity to provide new types of services, including in-home therapeutic and behavioral supports, mentors, and other services. Credentialing processes for in-home providers have been created to ensure quality, and CMOs were given small amounts of start-up funds to identify agencies that could provide these types of services.

North Carolina:

- The new critical access behavioral health agencies are engaging qualified providers for children's behavioral health services statewide.

Oklahoma:

- There has been considerable expansion of providers for home- and community-based services.

Rhode Island:

- The range of providers has been expanded through contracts with the Family Care Community Partnerships. Though previously the state contracted only with community mental health centers, other types of agencies (e.g., community action programs, community health centers) can now be included as lead agencies in the partnerships. Providers have been added to provide respite, mentoring, family support, wraparound facilitation, parenting skills training, care management, and other services.
- The certification process for wraparound has created a new category of providers.

Improving the Cultural and Linguistic Competence of Services

Creating or expanding the use of culturally and linguistically competent approaches to service delivery to improve outcomes to support expansion of the system of care approach

Activities are under way in the states to enhance the cultural and linguistic competence of their services, although these activities were generally not defined as strategies for expanding the system of care approach. The states described incorporating culture-specific services in their service array (as in Hawaii), recruiting culturally diverse providers (as in Maryland), and training (as in Oklahoma). In Arizona, a culture discovery process is seen as an integral part of the wraparound approach, and the cultural and linguistic competence of services at the practice level is measured using the System of Care Practice Review tool. This tool measures how well the system of care approach is applied at the service delivery level.

Examples: Cultural and Linguistic Competence of Services

Arizona:

- The child and family team process requires that strengths, needs, and culture discovery are part of the assessment, and training is provided for this. The state has also implemented the System of Care Practice Review instrument, which has a section on cultural and linguistic competence and measures how well it is implemented at the service delivery level.

Hawaii:

- As a diverse, multicultural state, efforts have been made to incorporate specialized services for culturally diverse populations (e.g., traditional healer services and other Eastern approaches to treatment) that are funded by Medicaid and other state funds.

Maine:

- The state has held conferences on multicultural issues and has focused on improving the cultural and linguistic competence of services at the local level, primarily through training.

Maryland:

- The state has focused on the recruitment of culturally sensitive and diverse providers (e.g., Afrocentric providers). A scholarship at an historically black college supports and mentors undergraduates to become child and adolescent mental health providers.
- Cultural and linguistic competence is a focus of system of care grants and is a component of the Wraparound Practitioners Certificate Program.

Michigan:

- Cultural and linguistic competence is emphasized as part of the service system but is not used as an expansion strategy.

New Jersey:

- Efforts to improve cultural and linguistic competence have been undertaken to improve the quality of services but not for system of care expansion per se. All CMOs are required to receive training in cultural and linguistic competence, and their boards are required to reflect the cultural and ethnic composition of their communities.
- The state requires that diversity and the ethnic composition of the community be considered in the recruitment of providers.

North Carolina:

- The state has developed a cultural competence plan and requires the LMEs to implement culturally and linguistically competent practices. Training is provided to support implementation.

Oklahoma:

- There is a state-level cultural competence coordinator, and training has been provided; however, it is not seen as a major strategy for system of care expansion.

Examples: Cultural and Linguistic Competence of Services (continued)
Rhode Island: • Language requiring cultural and linguistic competence has been incorporated into new regulations and standards. • The state has explored the use of a self-assessment tool to be administered at the administrative and practice levels.

Reducing Racial, Ethnic, and Geographic Disparities in Service Delivery

Developing and implementing strategies directed at reducing racial, ethnic, and geographic disparities in service delivery across child-serving systems to support expansion of the system of care approach

Similar to improving the cultural and linguistic competence of services, reducing disparities was identified as an important goal but was not generally defined as a strategy for system of care expansion. Several of the states have received grants that specifically target rural areas or communities of color (e.g., Maine's efforts to serve its Somali population). Interviewees noted that geographic disparities are reduced simply by expanding system of care approach statewide.

III. CREATING OR IMPROVING FINANCING STRATEGIES

Creating or improving financing mechanisms and using funding sources more strategically to support the infrastructure and services comprising systems of care to support expansion of the system of care approach

Table 6 summarizes the findings in this core strategy area.

Table 6. Financing

Creating or Improving Financing Strategies	
Most Effective Strategies	**Underutilized Strategies**
• Increasing the use of Medicaid • Increasing the use of federal system of care grants, Mental Health Block Grants, and other federal grants	• Redeploying funds from higher cost to lower cost services • Increasing the use of state mental health and substance use funds • Increasing the use of funds from other child-serving systems • Increasing the use of local funds • Increasing the use of federal entitlements other than Medicaid
New strategies to add to framework based on information generated through the study: • Implementing case rates or other risk-based financing approaches to increase flexibility in financing services and supports • Accessing new financing structures and funding streams (e.g., health reform, parity legislation)	

Most Effective Strategies

Increasing the Use of Medicaid

Increasing the use of Medicaid to finance services by adding new services, changing existing service definitions, obtaining waivers, using Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and using the rehabilitation option to finance services and supports to expand the system of care approach

Increasing the use of Medicaid to finance services and supports was the primary and most effective financing strategy that the states used. Three major approaches were used:

1. Expanding the array of covered services and supports by adding new service codes and definitions and by revising existing service definitions to cover services such as intensive home-based services, intensive outpatient substance use services, respite, family and peer support, treatment planning, wraparound process, therapeutic foster care, supported housing and employment, mobile crisis response, crisis stabilization, therapeutic behavioral aide services, skills training, traditional Native healers, specific evidence-based practices, assertive community treatment, and targeted care management
2. Using multiple Medicaid options and waivers to finance services and supports as seen in the options and waivers implemented in Michigan

3. Generating Medicaid match with funds from both mental health and other child-serving systems to draw down increased federal Medicaid funds, as in New Jersey where funds are pooled across mental health, child welfare, and Medicaid to draw down additional federal funds including funds from residential and group home services to be redirected to home and community-based services

Examples: Increasing the Use of Medicaid

Arizona:

- The children's mental health system is primarily based on Medicaid funding, with the state children's division managing a carve-out and using a capitation approach. Capitation rates have been increased and targeted to specific areas, particularly to increase the utilization of direct support and rehabilitation services. Medicaid coverage was expanded to cover a broad array of services and supports by adding new covered services and revising definitions for already covered services. A new agency category (community service agency) was created to provide direct support and rehabilitation services.

Hawaii:

- A Medicaid carve-out for children with serious mental health challenges was created and is managed by the state's Child and Adolescent Mental Health Division. Also, the state Medicaid plan was modified to add the broad array of services covered through the carve-out. A strong partnership with Medicaid resulted in identifying new services to add, fiscal incentives for community-based services, and potential savings.

Maine:

- The state has one of the highest rates of use of Medicaid for both mental health and developmental disabilities services. Coverage under Medicaid was expanded to include broad range of home- and community-based services and supports, and enhanced rates are offered for some evidence-based practices.

Maryland:

- A full array of services was added to Medicaid under the state's Psychiatric Residential Treatment Facility Waiver. This is how expansion of the system of care approach was "sold" in the state, as sustainable financing was obtained to fund services and supports.

Michigan:

- Increasing the use of Medicaid has been crucial for expansion. The range of covered services has been broadened significantly. Multiple waivers and options have been used, including a 1915(b) Managed Care Specialty Supports and Services Waiver; 1915(c) Home and Community-Based SED Waiver; 1915(c) Children's Waiver; 1915(c) Habilitation Supports Waiver, Clinic Option, Rehabilitation Option; Targeted Case Management; Psych Under 21; EPSDT; and Family of One.
- Child welfare funds have been blended with mental health funds to create Medicaid match dollars under the 1915(c) waiver, which has expanded resources for services outside of the capitation that have been used to serve children and families in the eight-county child welfare-mental health system of care pilot. This has had an enormous impact on increasing service capacity and system of care expansion.

New Jersey:

- An array of new services were added to the state Medicaid plan, such as mobile crisis response, in-home therapeutic services, and care management, using the rehabilitation option and targeted case management.
- Pooled funds across mental health, child welfare, and Medicaid were used as match to draw down additional federal funds that have been crucial for system of care expansion. Residential and group home resources were included in the pool and redirected to home- and community-based services.

Examples: Increasing the Use of Medicaid (continued)
North Carolina: • The state moved to the Rehabilitation Services Option and expanded the array of covered services and supports by adding new services and revising existing service definitions both to clarify them and to increase the quality of services. **Oklahoma:** • New service codes have been added to Medicaid to broaden the array of covered services (e.g., new codes to cover the wraparound process). **Rhode Island:** • A global 1115 Medicaid waiver defines a population at risk for out-of-home placement, hospital, or residential levels of care to be served with an array of home- and community-based services. A partnership and resulting agreement with the Medicaid agency has expanded coverage to include a broader range of services and supports, such as early childhood mental health services, specific evidence-based interventions, family service coordinators, and the wraparound process, among others.

Increasing the Use of Federal Grants to Finance Systems of Care

Maximizing the use of federal system of care grants, Mental Health Block Grants, and other grants to develop and finance system of care infrastructure and/or services and to leverage other funding to support expansion of the system of care approach

Federal grants, especially CMHI grants, have been used to support statewide expansion of systems of care. These grants have been used strategically as vehicles for leveraging other long-term financing sources. Maine and Rhode Island are examples of states that have used system of care grants strategically to put in place structures and long-term financing for statewide system of care implementation. In Maryland, multiple federal grants have been linked and have built on one another to move statewide expansion forward.

Federal Mental Health Block Grants have also been used to fund activities that support statewide expansion. For example, counties in Michigan can apply for Mental Health Block Grant funds to support system of care planning.

Examples: Federal Grants (System of Care Grants, Mental Health Block Grants, and Others)
Arizona: • Block Grant funds have been used as a funding source for services not covered under Medicaid, such as concrete services or supports that are included a child's individualized service plan. **Hawaii:** • Grants are not used as an expansion strategy but to test out new intervention approaches with priority populations. **Maine:** • Mental Health Block Grant funds have been used to support training, TA, and youth and family organizations. • The state has had multiple system of care grants that have been used strategically to finance infrastructure and services that could then be financed through other long-term approaches.

Examples: Federal Grants (System of Care Grants, Mental Health Block Grants, and Others) (continued)

Maryland:

- The state has had multiple system of care grants that have been used strategically to support expansion.
- Multiple federal grants and funding sources have contributed to system of care expansion, including grants from the Children's Health Insurance Program Reauthorization Act (CHIPRA), a Psychiatric Residential Treatment Facility Demonstration Waiver, a Transformation Grant, a Healthy Transitions Grant, a Suicide Prevention Grant, a Seclusion and Restraint Grant, and a National Institutes of Health Science to Services Grant.

Michigan:

- Mental Health Block Grant funds have been used to support expansion. In the last five Block Grant cycles, community mental health agencies were asked to submit proposals for funds to support system of care planning and implementation. Funds may be used for a variety of purposes, such as funding a facilitator to lead the planning and implementation process.

New Jersey:

- The state had an early system of care grant that essentially served as a pilot for statewide expansion. Although New Jersey has not received other system of care grants, the state has found other long-term financing strategies to support systems of care.

North Carolina:

- The state has had multiple system of care grants and a child welfare system of care grant. These grants have helped the state to move toward statewide expansion by leveraging local funds and making the case for the effectiveness of the system of care approach so that additional state funds could be obtained.

Oklahoma:

- System of care grants have been critical for expansion efforts by providing resources to fund efforts in local communities, as well as by providing infrastructure at the state level to support community efforts.

Rhode Island:

- The state has had multiple system of care grants that have been used strategically for statewide system of care implementation.

Underutilized Strategies

Increasing the Use of State Mental Health and/or Substance Use Funds

Obtaining new or increased state mental health and/or substance use funds to support system of care infrastructure and services and support expansion of the system of care approach

The strategy of obtaining new or increased state mental health funds has not been used for expansion, due primarily to the lack of availability of these funds in the context of state budget crises. Although some mental health general revenue funds may have been used previously to support services not covered under Medicaid, budget cuts have had a dramatic effect on their current availability. In North Carolina, however, state mental health funds have been used for statewide conferences on the system of care approach, support of LMEs and their system of care coordinators, school-based system of care coordinators, and collaborative activities. State funds in Maryland pay for crisis response and respite services for children who do not qualify under their Psychiatric Residential Treatment Facility Medicaid waiver. No state reported using state substance use funds as a strategy for expanding the system of care approach.

Increasing the Use of Funds From Other Child Serving Systems

Obtaining new or increased funds from other child-serving agencies and/or coordinating, braiding, blending, or pooling funds with other child-serving agencies to finance infrastructure and/or services and support expansion of the system of care approach

Using funds from partner child-serving systems has worked well in several states but overall is an underutilized expansion strategy. For example, in Michigan, child welfare funds are currently used to support systems of care in eight counties, with plans for statewide expansion. Child welfare and juvenile justice funds have supported both wraparound and specific evidence-informed interventions in Maine. In Rhode Island, funds across child-serving systems are being used to support statewide system of care implementation. In Maryland, the Children's Cabinet is a vehicle for blending resources across agencies to fund the services provided by CMEs.

Examples: Funds From Other Child-Serving Systems

Maine:

- Significant funding from child welfare has supported Wraparound Maine. The corrections agency provided funds for start-up costs related to the implementation of Multisystemic Therapy, Functional Family Therapy, and Multidimensional Treatment Foster Care.

Maryland:

- The Children's Cabinet has spearheaded interagency financing and blending of resources. For example, slots in the CMEs are funded through interagency funds and child welfare also provides funds for crisis services.
- State agency funds support payments for specific evidence-based practices for children in their care.

Michigan:

- Child welfare general revenue funds have been redirected to match Medicaid dollars and serve children and youth who may not necessarily meet the criteria for hospitalization under the 1915(c) waiver but need intensive services. Child welfare funds are being used to support systems of care in eight counties as a pilot that will eventually be implemented statewide.
- Funds are blended at the local level, typically among mental health, child welfare, and juvenile justice. A case rate with blended dollars in one county includes a full range of home- and community-based services and supports and serves youth referred by child welfare or juvenile justice with serious mental health needs and who are at risk for out-of-home placements.

New Jersey:

- The pooling of child welfare funds (that previously supported residential treatment and group homes) with mental health and Medicaid resources enabled the state to draw down increased federal funds that have been the primary mechanism for financing statewide system of care expansion.

North Carolina:

- Some support from other systems has been obtained for the state collaborative and some child welfare funds have helped to support child and family teams in Mecklenburg County; however, this has not been used as a major expansion strategy.

Oklahoma:

- Joint budget requests have been developed across systems.

Rhode Island:

- The state analyzed and identified what funds were being spent on children's mental health services across systems (education, health, child welfare, juvenile justice, and so forth) to determine what funds could be used in a more targeted way. This has resulted in the braiding of various funding streams to implement the two phases of statewide system of care expansion.

Redeploying Funds From Higher Cost to Lower Cost Services

Redeploying, redirecting, or shifting funds from higher cost to lower cost services to finance infrastructure and/or services and support expansion of the system of care approach

The process of redeploying funds from high-cost residential and inpatient services to lower cost home- and community-based services is underutilized, although this strategy has proven effective in states such as Maine, Michigan, and New Jersey. In some instances, savings from reduced utilization of inpatient and residential services have had to be returned to state treasuries in the current fiscal environment, rather than being reinvested in community-based services and supports. In Rhode Island, a cap on beds has been established; 50 percent of the savings is reinvested in home- and community-based services, and the other 50 percent is returned to the state's treasury.

Examples: Redeploying Funds

Arizona:
- The state's goal is to reduce the utilization of residential treatment as the utilization of home- and community-based services increases. Progress has been made in shifting resources to home- and community-based services by creating new services, adding new types of providers, increasing Medicaid coverage, and other actions.

Hawaii:
- Redeployment of funds has not been used as an expansion strategy. Success in reducing residential utilization has helped to avoid some budget cuts but has not resulted in redeployment.

Maine:
- The residential population has been reduced significantly and the funds have been redeployed to support Wraparound Maine.

Maryland:
- When a state-run residential treatment center was closed, the funds were used to address the general budget deficit rather than to support the expansion of home- and community-based services. Given the budget situation, Maryland is focusing on cost neutrality and improving the efficiency, effectiveness, and quality of care.

Michigan:
- Redirecting funds is seen as an important financing strategy. The goal of the current child welfare–mental health collaboration is to divert or move children out of residential treatment and to redeploy those resources to support community-based services.

New Jersey:
- Resources supporting residential and group home services from child welfare and mental health were redirected to support the system of care infrastructure and services statewide. Residential programs shifted over time rather than abruptly redeploying all of their funding.

North Carolina:
- The state has had significant success in reducing residential care but has not been able to redeploy these funds because of overall budget issues.

Oklahoma:
- There has been some reduction in the use of residential care but resources have been returned to the state's general fund rather than being redeployed.

Examples: Redeploying Funds (continued)
Rhode Island: • Funds spent on deep-end services are being reinvested in home- and community-based services. A cap on beds has been established; 50 percent of the savings goes into financing community-based services and the other 50 percent is returned to the state's general fund. This strategy will become increasingly important with the implementation of the second phase of the expansion initiative, which is focusing on moving youth from deep-end placements into home- and community-based services.

Increasing the Use of Local Funds

Obtaining new or increased local funds (e.g., taxing authorities, special funding districts, county funds) to finance infrastructure and/or services and support expansion of the system of care approach

Local funds are not being used as an expansion strategy in most states studied. In Michigan, the child welfare system has county child care funds, and decision-making power about the use of those funds is at the local level. With approval from the state child welfare agency, counties can redirect these funds and blend them with mental health funds to draw down additional federal Medicaid funds. One Michigan community has a juvenile justice millage (i.e., property tax) that funds some system of care activities, such as an alternative school and recreation programs. Other communities may be considering the idea of a millage.

Increasing the Use of Federal Entitlements Other Than Medicaid

No state reported using other federal entitlements as a source of funding for system of care infrastructure or services. There was consensus among key informants that this financing strategy was not viable for expanding the system of care approach.

IV. PROVIDING TRAINING, TECHNICAL ASSISTANCE, AND COACHING

Implementing workforce development mechanisms to provide ongoing training, TA, and coaching to ensure that providers are prepared and skilled to provide effective services and supports consistent with the system of care philosophy and approach

Table 7 summarizes the findings in this core strategy area.

Table 7. Training and Workforce Development

Providing Training, TA, and Coaching	
Most Effective Strategies	**Underutilized Strategies**
• Providing training, TA, and coaching on the system of care approach • Creating ongoing training and TA capacity	• Providing training, TA, and coaching on evidence-informed and promising practices and practice-based evidence approaches

Most Effective Strategies

Providing Training, TA, and Coaching on the System of Care Approach

Providing ongoing training, TA, and coaching on the system of care philosophy and approach to support expansion of the system of care approach

Training has been a vital expansion strategy in all of the states studied. Substantial resources have been invested in providing training and TA on the system of care approach. Outside consultants, partnerships, and contracts with universities; state staff; and system of care communities have all provided vehicles and resources for developing a workforce that is skilled and prepared to work within a system of care framework. For example, Arizona brought consultants into the state to provide training in wraparound. In Maine, a federally funded system of care community provides training to other communities on the system of care approach and evidence-informed interventions. Partnerships with universities have been used in North Carolina, Hawaii, and Maryland. Michigan includes a state-employed wraparound trainer on staff.

Examples: Training on the System of Care Approach

Arizona:

- Training on the system of care approach and child and family team practice was a significant component of early implementation efforts. Consultants with expertise were brought into the state to provide core training in the system of care approach and to train wraparound facilitators. At this stage of development, much of the training has been turned over to the regions and RBHAs are required to provide training to support systems of care and wraparound practice.

Hawaii:

- Contracts with the state university and some private universities have been used strategically to shape university curricula to support the priorities of the public children's mental health system and to provide training on the system of care approach. Contracts have supported courses on systems of care, evidence-based practice, and other critical subjects. University faculty members serve on various state children's division committees. Trainees across mental health disciplines rotate through the children's system to obtain training and experience in the system of care approach.

Examples: Training on the System of Care Approach (continued)

Maine:

- A system of care grant community has been used to provide training on the system of care approach, using Webinars as a primary mechanism. Extensive training is provided on the role of youth. Learning collaboratives related to trauma-informed care and systems of care have also been created to provide training to other communities.

Maryland:

- Extensive training on the system of care approach and wraparound practice has been provided through the Innovations Institute at the University of Maryland. Through a contract with the state, the Institute provides training and coaching on the system of care approach.
- The state has developed a certification program for wraparound that is offered statewide.
- An annual Training Institute provides training on the system of care approach for policy makers, researchers, direct service providers, community members, families, and youth.

Michigan:

- Mechanisms to provide training on the system of care approach and the individualized service process include an annual system of care conference, TA to communities to assist them with system of care implementation, ongoing statewide training on wraparound (including a full-time, state-employed wraparound trainer), and grants to communities with Mental Health Block Grant funds to support facilitators to assist with system of care planning. This training has created increased knowledge, skills, and commitment to pursue the system of care approach statewide.

New Jersey:

- Training on the system of care approach was incorporated at the outset of New Jersey's expansion initiative and continues to be available statewide. Regional and county training has been provided on system of care values and principles, specific services, care management, use and certification for instruments and tools (such as the strengths and needs tool), and other topics and has been followed by onsite coaching and TA. Statewide training has been provided on wraparound and the child and family team process.

North Carolina:

- The state has collaborated with universities to provide training on the system of care approach. For example, the University of North Carolina at Greensboro has provided training both in the community and to its own students.
- A training committee under the state-level collaborative has focused on child and family teams.
- A current system of care grant site has been used to provide training in infrastructure and service delivery aspects of systems of care and also provides some coaching.

Oklahoma:

- The state has provided annual training in the system of care approach, and system of care grant funds have been used to provide training on the system of care approach and wraparound.
- A 4-day wraparound training program supplemented with follow-up coaching has been provided by system of care grant sites.

Rhode Island:

- Training has been an integral part of the state's strategy. Training and TA with system of care grant resources have been used to support statewide expansion efforts. For example, Primer Hands On training has been provided statewide. A wraparound training program with follow-up coaching has been provided, and the state is developing its own certification process for wraparound.

Creating Ongoing Training and TA Capacity

Creating the capacity for ongoing training and TA on systems of care and evidence-informed practices (e.g., institutes, centers of excellence, TA centers, intermediary organizations, partnerships with higher education) to support expansion of the system of care approach

The capacity for ongoing training is also seen as a highly effective strategy. Particularly given the turnover among administrators, managers, and providers, ongoing training is considered key to expansion and continued development and improvement of the workforce. Both Maryland and New Jersey have established centers at universities that provide ongoing training, while capacity has been created at local system of care sites and provider agencies in Michigan, Maine, and Oklahoma.

Examples: Training Capacity

Arizona:

- A provider organization was funded to provide training to other providers in direct support and rehabilitative services.

Hawaii:

- The capacity for training was created within the state children's division through practice development specialists. Additional capacity was created through contracts, particularly with the state university.

Maine:

- Capacity for ongoing training was created through a contract with a system of care site that has been used strategically to provide training to expand the system of care approach and effective practice, with a focus on trauma-informed care.

Maryland:

- A contract with the Innovations Institute at the University of Maryland has created the capacity for ongoing training on the system of care approach and evidence-based practices statewide.
- A virtual workforce development center was created to provide online training and Webinars on a variety of topics related to system of care.

Michigan:

- The state has established training capacity at several community agencies to provide and coordinate training on evidence-based practices within a system of care context. These agencies oversee the statewide infrastructure to support and sustain these practices.
- Centers of excellence have been created at system of care sites. Rather than establish one entity to fulfill multiple training functions, these entities provide training in their particular areas of expertise and are closer to the direct service providers delivering those services.

New Jersey:

- Training capacity has been created with a contract to the Behavioral Research and Training Institute at the University of Medicine and Dentistry of New Jersey. The contract funds more than 30 trainings per month on topics related to the system of care approach.

North Carolina:

- Training capacity has been established at five universities through contracts with the state. Through this mechanism, statewide training has been provided on the system of care approach, wraparound, and evidence-based practices. The state collaborative is working to provide more coaching.

Oklahoma:

- Training capacity has been created in system of care grant sites that provide training on all aspects of systems of care, with a strong focus on wraparound and family partnerships. Training is provided by staff that are supported by system of care grants.

Rhode Island:

- The Child Welfare Institute at Rhode Island College has been used to provide training on the system of care approach and training and certification on wraparound.

Underutilized Strategies

Providing Training, TA, and Coaching on Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches

Providing ongoing training on evidence-informed and promising practices and practice-based evidence approaches to support high-quality and effective service delivery to support expansion of the system of care approach

Training on effective practices has generally not been used systematically as a strategy to support system of care expansion. This strategy has the potential to improve outcomes, and thereby garner support for expansion efforts, but was generally not used for expansion purposes. Exceptions are found in Maryland, where the Innovations Institute is the hub for statewide training on evidence-informed services, and in Michigan, where community agencies provide training on the specific evidence-informed practices that are being implemented statewide. Training is also provided in Maine on effective services such as Trauma-Focused Cognitive Behavior Therapy and Multisystemic Therapy.

Examples: Training on Evidence-Informed and Promising Practices

Arizona:

- Training modules have been developed on the direct support and rehabilitative services that have been added to the service array. Targeted training is provided to high-need case managers on meeting the unique needs of children in child welfare, for example.
- After initial state training and coaching on child and family team/wraparound practice in the early stages of system of care expansion, most training on effective services is regionally based.

Hawaii:

- The Child and Adolescent Division's Clinical Services Office has had a focus on improving provider practice in evidence-based interventions, evidence-based practice components, core practice elements such as assessment and engagement, the use of measurement tools, and similar areas. State-employed practice development specialists have provided consultation, training, and supervision to staff and contracted providers.

Maine:

- Agencies that provide trauma-focused services, Multisystemic Therapy, Functional Family Therapy, and others provide training to other agencies to assist in expanding the use of these practices.

Maryland:

- The Innovations Institute at the University of Maryland serves as the hub for training on evidence-based practices statewide and ongoing coaching is embedded into the approach. For example, training and coaching are provided on Multisystemic Therapy.
- Certificate programs are offered by the University of Maryland, including one on effective services for early childhood mental health.

Michigan:

- Several community agencies with expertise have been engaged to provide statewide training on specific evidence-based practices. One community oversees all training on Parent Management Training–Oregon Model, and another coordinates statewide training on Trauma-Focused Cognitive Behavior Therapy.

New Jersey:

- Planning is under way to create a statewide center of excellence to incorporate training on evidence-based practices into the state's work on the system of care approach.

Examples: Training on Evidence-Informed and Promising Practices (continued)

North Carolina:

- Training on effective practices is not used as an expansion strategy and has been locally based.

Oklahoma:

- The state has provided training on Trauma-Focused Cognitive Behavior Therapy and Parent-Child Interaction Therapy through its system of care grant and has instituted a certification process for wraparound.

Rhode Island:

- Training on effective practices has not been used as an expansion strategy but has been offered by providers.

V. GENERATING SUPPORT

Generating support among families and youth, high-level decision makers at state and local levels, providers, managed care organizations, and other key leaders to support expansion of the system of care approach

Table 8 summarizes the findings in this core strategy area.

Table 8. Support

Generating Support	
Most Effective Strategies	**Underutilized Strategies**
• Establishing strong family and youth organizations to support system of care expansion • Generating support among high-level policy makers and administrators at state and local levels	• Using data on outcomes and cost avoidance to promote expansion • Cultivating partnerships with providers, provider organizations, managed care organizations, and other key leaders • Generating support through social marketing and strategic communications with key audiences • Cultivating leaders and champions for the system of care approach

Most Effective Strategies

Establishing Strong Family and Youth Organizations

Establishing strong family and youth organizations to support and become involved in expansion of the system of care approach (e.g., through funding, involvement at the system and policy levels, contracting for training and services)

A highly effective strategy identified by the states is supporting the development of strong family organizations that take a leadership role in supporting and becoming closely involved in statewide expansion efforts. Typically, this is accomplished through state contracts with family organizations that support family involvement at the system level. The role of family organizations has been instrumental in most states. For example, in Maryland, the statewide family coalition is credited with having a significant impact on maintaining expansion efforts in the face of administration changes and budget deficits.

The development and role of youth organizations is considerably behind that of family organizations in all of the states. Youth organizations are sometimes embedded in family organizations, such as in Hawaii, Michigan, and New Jersey. The national youth organization Youth M.O.V.E. (Youth Motivating Others through Voices of Experience) is becoming increasingly involved in national policy and in supporting the development of state and local youth organizations. Youth organizations are in early stages of assisting with system of care expansion efforts through public education and outreach to key constituencies.

Examples: Strong Family and Youth Organizations

Arizona:

- The state contracts with the Family Involvement Center in Maricopa County, which plays a significant role, and also contracts with another family organization (MIKID) that also plays a role in promoting system of care expansion. The contract provides for family involvement at the system level. A statewide family committee advises state leaders on issues related to system of care. The organizations have been instrumental in supporting system of care expansion.
- The Family Involvement Center has become a Medicaid provider of family support services.
- The state funds youth advocates and youth leadership development activities through contracts with family organizations. Efforts to develop a youth organization are under way.

Hawaii:

- The state contracts with the statewide family organization (Hawaii Families as Allies) for participation in policy-level and system-management activities. Family leaders participate on a range of committees and children's councils throughout the state, thus providing multiple forums for supporting system of care expansion.
- A new youth organization embedded in the family organization is in early stages of development.

Maine:

- The state has supported the development of strong family and youth organizations primarily through its Mental Health Block Grant funds and the organizations have provided extensive training. For example, more than 800 parents were trained across the state in 2009.
- Maine has also supported the development of a strong Youth M.O.V.E. chapter by using Mental Health Block Grant funding.

Maryland:

- The state contracts with the Maryland Coalition of Families for Children's Mental Health, which has been a significant advocacy force and has been instrumental in keeping the system of care expansion effort moving forward through changes in state administrations. The coalition has had access to the Children's Cabinet, Office for Child and Family Services in the Department of Health and Mental Hygiene, and other high-level decision makers and has been successful in legislative and policy arenas. The coalition is written into every state grant.
- A Youth M.O.V.E. chapter is in early stages of development.

Michigan:

- The state has supported the state's FFCMH chapter with a contract using Mental Health Block Grant funds for more than 20 years. The contract supports family advocacy positions and policy-level participation among other functions, and the organization has played a strategic role in system of care expansion.
- The contract with the statewide family organization also supports a youth leadership council that is currently working on an antistigma campaign. A youth leadership camp is held each year. The state also funds a community mental health agency in Detroit to support a youth organization primarily composed of minority youth in the community.

New Jersey:

- A Family Support Organization is required in each area that is attached to the CMO. A statewide family organization (the New Jersey Alliance of Family Organizations) is funded through state contracts and is primarily responsible for supporting the community family organizations. The statewide organization has had some influence on statewide system of care expansion.
- Starting with the early system of care grant in Burlington County, the state has allocated some funds to each county to develop and house a youth partnership within each Family Support Organization. A youth council was also created at the state level.

Examples: Strong Family and Youth Organizations (continued)

North Carolina:

- Mental Health Block Grant funds support the family organization that has promoted system of care development through training and education.
- Some Mental Health Block Grants funds have been allocated to develop a youth organization, which is in early stages of implementation.

Oklahoma:

- A statewide FFCMH chapter and 31 local family groups have provided a vehicle for families to promote system of care expansion. The groups have organized coffee chats and implemented other strategies to generate support among legislators. System of care grant funds help to support the strategy.
- Twenty-six youth groups are also a part of the FFCMH and are in the early stages of development.

Rhode Island:

- The state has worked with the Parent Support Network of Rhode Island (FFCMH chapter) through a contract that provides for family leadership development in the regions and for family voice at policy and system levels, among other functions. Families have had a strong voice, including testifying for the legislature to promote system of care expansion.
- Families and youth make up 51 percent of a statewide family-community advisory board.
- Four family leaders are connected to each of the Family Care Community Partnerships to develop family leaders.
- The state employs a youth coordinator to develop youth leadership.

Generating Support Among High-Level Policy and Decision Makers

Generating political and policy-level support for the system of care philosophy and approach among high-level administrators and policy makers at state and local levels to support expansion of the system of care approach

Support among high-level decision makers was identified as a requirement for statewide expansion of the system of care approach. Efforts to garner support have focused on state-level policy and decision makers. A variety of approaches are used including providing data, educational briefings, concept papers, plans, reports, and meetings with families and youth. In Michigan, high-level decision makers have been included in delegations to federal meetings (e.g., system of care training institutes, policy academies) to engage them in expansion efforts. The Children's Cabinet in Maryland has been fully engaged in system of care expansion and its members have become champions for the approach. Support from the legislature and governor were reported to be critical for system of care expansion in Rhode Island, and system of care leaders thought strategically about how to involve key policy makers in opportunities to support system change.

A focus on gaining the support of local decision makers was identified in Rhode Island, where concept papers were used to engage local leaders. In North Carolina and Oklahoma, local collaboratives work to garner support among local decision makers.

Examples: Support From High-Level Policy and Decision Makers

Arizona:

- The Arizona Children's Executive Committee comprises high-level administrators across child-serving agencies and the state Medicaid system. This structure has been used strategically to advance the agenda of statewide system of care implementation.

Hawaii:

- The state enjoyed substantial high-level support while their class-action lawsuit's settlement agreement was in effect. Since the termination of court involvement, more effort has gone into developing support among high-level administrators across systems.

Maine:

- The state has reached out to develop support among high-level decision makers. This outreach has included nontraditional agencies such as the Department of Labor and Adult Education.

Maryland:

- High-level support at the state level has been a critical strategy, with legislators, the governor's office, the state's first lady, and others being strong proponents of systems of care. Support has been achieved primarily through education about systems of care and their effectiveness through a planful, targeted, and coordinated approach.
- The Children's Cabinet has been a vehicle for engaging high-level administrators across agencies who have become strong champions for the system of care approach. Cabinet members have extensive knowledge about systems of care, CMEs, and other efforts to improve home- and community-based services.

Michigan:

- Support from the mental health commissioner, director of Medicaid, director of community health, child welfare administrators, court system administrators, and others have been pivotal in moving system of care expansion forward.
- One strategy for garnering support has been to bring these individuals to national training and TA events such as system of care training institutes, federal system of care meetings, policy academies, and others.
- With the change in administration, PowerPoint presentations, talking points, data, and family stories have been prepared to raise awareness and cultivate support among new decision makers.
- Letters from the mental health commissioner and head of child welfare have been sent to all local community mental health and child welfare directors regarding the system of care agenda and commitment to family-driven, youth-guided services.
- Local strategies, often implemented by family members, target city councils, county commissioners, school administrators, and others to generate support for systems of care.

New Jersey:

- Support from the governor's office was a highly effective strategy for system of care expansion. For example, support was generated at the governor's level and among high-level policy makers in state government by demonstrating that a system of care would prevent parents from having to give up custody of their children to obtain services. Family stories played a significant role in this strategy. Continued support among state policy makers has been maintained, even with five governors within the past 6 years and accompanying changes in commissioners and other administrators.

North Carolina:

- Support among high-level decision makers at the state level has been generated through participation on state collaboratives that comprise state and local leaders and family members.
- Local collaboratives are responsible for generating support among high-level decision makers at the local level.

Examples: Support From High-Level Policy and Decision Makers (continued)

Oklahoma:

- Support from commissioners across agencies has been critical in system of care expansion and has been generated by development of a shared vision and commitment to systems of care.
- The state advisory team includes high-level decision makers across systems, as well as representatives of other, less-traditional sectors such as the faith community.
- Local coalitions are used as a vehicle to generate support among high-level local decision makers.

Rhode Island:

- Support from the legislature and governor were reported to be critical for the system changes needed for system of care expansion. System of care leaders thought strategically about how and when to involve key policy makers (i.e., budgets and other opportunities to support system change). An important strategy has been to maintain awareness of the political process and to know to whom, when, and how to generate support. Legislation promoting system of care expansion has resulted.
- At the local level, concept papers were disseminated to local leaders to engage key policy and decision makers, obtain their feedback, and incorporate their ideas throughout planning and implementation.

Using Outcome Data

Using data on the outcomes of systems of care and services to promote expansion of the system of care approach

Data on outcomes at both the system and service delivery levels are important components of garnering the support of decision makers for statewide expansion. In Maine and Oklahoma, for example, data are presented to legislators and other policy makers. In Maryland, effectiveness data from various pilots helped to promote statewide implementation. North Carolina has used outcome data from federally funded system of care communities to generate support for expansion.

Examples: Outcome Data

Arizona:

- Progress has been achieved in using data to make the case for system of care expansion. The state monitors outcomes, utilization, and quality; the System of Care Practice Review has been adopted; and the Child and Adolescent Service Intensity tool is used to determine the need for high-level case management. Data dashboards are being tested at the regional authority level. Data are used to guide the development of annual plans and to present to legislators and other key stakeholders to support expansion.

Hawaii:

- The use of data has been one of the state's primary strategies for supporting expansion. Data are collected on many aspects of performance related to the system of care approach, such as access, least-restrictive setting, clinical and functional outcomes, use of out-of-home placements, and so forth. Expansion occurred primarily through a class-action lawsuit, but data have been used with decision makers and legislators to maintain the progress that was made.

Maine:

- The state has used data from a system of care site, CAFAS data, and national system of care data to prepare reports for the state legislature, as well as to provide data to providers and family organizations. Quantitative data are combined with personal stories to elicit support. Data have comprised an important strategy in the work of Maine's Thrive system of care grant.

Examples: Outcome Data (continued)

Maryland:

- Data from pilots have been used as a base for expansion. For example, pilots in early childhood mental health were used to provide data on the effectiveness of early childhood mental health consultation to justify statewide expansion of the approach. Data from a wraparound pilot showed positive outcomes from the child and family team approach that supported statewide implementation.

Michigan:

- The state has implemented a system to use outcome data, based on the CAFAS, at the service delivery level that can be reported by individual children, caseload, agency, and statewide. The CAFAS is Web-based, and all community mental health agencies are online to use this tool. Data are used both to improve services and to support system of care expansion based on positive outcomes. Data are woven into every communication with stakeholders.

New Jersey:

- There were not a lot of data in the early stages to support system of care expansion, but more data are currently available to demonstrate improvements and areas in which improvements are still needed. Data in combination with family stories has been an effective strategy for generating support.

North Carolina:

- Data from local system of care grants have been used to generate support from the legislature. Outcome data from the national evaluation of the system of care grants are also used to help make the case for system of care expansion.
- The state has developed a statewide children's mental health reporting system that provides information on children's needs and outcomes.

Oklahoma:

- A strong focus on data comprises a strategy to generate support. Data are reported monthly in easy-to-read formats on a limited number of key measures statewide and are also collected monthly by county.
- The University of Oklahoma has been involved in system of care evaluation, which has helped to provide additional credibility to the findings.

Rhode Island:

- The state has increased the availability of data following implementation of a new management information system.

Underutilized Strategies

Using Cost Avoidance Data

Using data on cost avoidance across systems and comparisons with high-cost services to promote statewide system of care expansion

An approach used less frequently involves using data on cost avoidance across systems and/or comparisons with high-cost services to make the case for statewide expansion. Given the difficult economic situation in most states and the lack of new monies, it is important to demonstrate that the system of care approach results in reduced utilization of inpatient and residential treatment placements while at the same time showing positive clinical and functional outcomes. Oklahoma and Michigan have been able to demonstrate cost avoidance based on reducing the utilization of residential treatment centers and other out-of-home services. Other states studied did not report using this approach.

Examples: Cost Avoidance Data

Hawaii:

- The state has collected cost-benefit data through a process called data envelope analysis that examines relative efficiencies of the family guidance centers by analyzing costs and outcomes. These data have been used for performance assessment and continuous quality improvement rather than for supporting expansion.

Maine:

- Data from Wraparound Maine showing reductions in the use of residential care and consequent cost avoidance have been used for quality improvement and to support system of care expansion.

Maryland:

- The focus has not been on cost avoidance, although cost data helped to identify the initial population to be served by the CMEs—those who were in high-cost, restrictive, out-of-home placements. The state's current focus is on cost neutrality, efficiency, effectiveness, and quality of care.

Michigan:

- In the pilot with child welfare, costs are being tracked to compare the costs of children in residential treatment (child welfare has had a high rate of youth in residential treatment centers) and in community-based services through systems of care. The pilot has already resulted in reducing the residential treatment center population by 30 percent.

New Jersey:

- Some data on the cost-effectiveness of the system of care approach from other states were used to generate support in the early stages of expansion but New Jersey did not have its own cost data.

North Carolina:

- Data have been gathered on reductions in the use of residential treatment but specific cost avoidance data have not been used as an expansion strategy.

Oklahoma:

- Data have been presented showing the financial implications of reductions in out-of-home care. These data have been used to generate support among legislators.

Rhode Island:

- Early in the expansion process, the state used data from other states to demonstrate that a shift in practice to home- and community-based services would be cost effective to generate initial buy-in. The state now has its own data to demonstrate the cost difference between community-based services and long-term hospitalization, which has been projected over time. Data also are used to show how many children would have entered care within the Department of Children, Youth, and Family Services without the services provided by the Family Care Community Partnerships.
- The second phase of implementation will provide data on savings from youth being shifted and diverted from deep-end placements.

Cultivating Partnerships With Providers and Other Leaders

Cultivating partnerships with provider agency and organization leaders, managed care organizations, and civic leaders and advocates to support expansion of the system of care approach

To some extent, states have intentionally pursued partnerships with providers, provider agencies, and managed care organizations to engage them in expansion efforts but this generally has been an underutilized strategy. One exception is in Michigan, where the state works closely with the children's mental health leaders in each community mental health agency on system of care implementation issues. Also, Rhode Island seeks input from community providers on all plans and policy documents, creating buy-in and commitment to the system of care approach. Work to

generate support from various types of civic leaders was generally not cited as an expansion strategy.

Examples: Partnerships With Providers, Managed Care Organizations, and Other Leaders

Arizona:

- The state has cultivated strong relationships with provider agencies, which is considered important for promoting the system of care approach. Committee structures include providers, who are encouraged to provide input.
- Expectations for collaboration with providers and other key stakeholders at the community level are incorporated into the state's contracts with RBHAs.

Maine:

- The state has reached out to and met with providers and administrators from key sectors and has been successful in gaining support for the move to a trauma focus. The state has also developed partnerships with child-serving agencies and other agencies, such as labor and adult education, to generate support for the system of care approach.

Maryland:

- The state has reached out to a wide range of stakeholders, including provider organizations, to generate support.

Michigan:

- Each community mental health agency is required to have an individual designated as responsible for children's services. The state meets monthly with these children's administrators to provide a forum to share information and new directions, discuss implementation issues, and garner support for expansion.
- The state has worked with coalitions such as the Association of County Health Agencies to raise awareness and cultivate support.

New Jersey:

- The state has implemented efforts to cultivate support among provider organizations, community leaders, and other key leaders but such partnerships are more likely at the local level. Care Management Organizations meet regularly with providers, most of whom now accept the system of care approach despite initial resistance.

North Carolina:

- Key stakeholders are represented on collaboratives and the advisory council for the Mental Health Block Grant, but the main focus has been on the LMEs and the coordinators as vehicles for generating support and commitment.

Oklahoma:

- Support among providers has been generated through site visits, securing their input, and involving them in training.
- State and local teams have included key stakeholders, such as community and faith leaders.

Rhode Island:

- The state strategy has been to develop drafts of all plans, standards, and other policy documents and then to seek input from community providers and other key stakeholders through focus groups, community meetings, and other avenues. This is seen as a way of practicing system of care principles in the development of systems of care by creating a participatory process that creates buy-in and commitment to the approach.

Generating Support Through Social Marketing and Strategic Communications

Informing key constituencies and audiences about the value and merits of expanding the system of care approach and creating a sense of urgency for addressing children's mental health through social marketing and strategic communications

Although social marketing activities were reported, most states did not characterize social marketing as an important strategy for expanding the system of care approach. Despite not being cited as a specific expansion strategy, social marketing and strategic communications have, in fact, permeated many of the expansion strategies reported as effective. An example of the effective use of social marketing is found in Maryland, where the first lady became a spokesperson for children's mental health, generating strong support for statewide system of care implementation.

Examples: Social Marketing and Strategic Communications

Maine:

- Social marketing is used to promote system of care expansion, particularly by the family organization and Youth M.O.V.E., including the creation of digital stories, activities for Children's Mental Health Awareness Day, public service announcements, an antistigma campaign, a suicide prevention walk, and similar events.

Maryland:

- Social marketing is used as a strategy to garner support for continuation and expansion, particularly during children's mental health awareness month. State and family system of care leaders have been on TV with Maryland's first lady and other honorary chair people to cultivate broad-based support. The state's children's mental health awareness campaign has won prizes and the number of events in the state has increased dramatically, including TV and radio spots and advertisements on the sides of city buses.

Michigan:

- Social marketing was not cited as an expansion strategy, although communities have used social marketing to raise awareness and cultivate support, including Children's Mental Health Awareness Day activities, an annual award luncheon, videos on YouTube, newsletters, a Facebook page, and so forth

New Jersey:

- The family organization has undertaken social marketing to generate support for the expansion initiative.

Oklahoma:

- Social marketing has been undertaken through a state-level position funded by a system of care grant. Activities have included system of care branding, an antistigma campaign, a Web site, a quarterly newsletter, and other strategies to generate support for expansion among key constituencies.

Rhode Island:

- The family organization is the lead contractor for social marketing on systems of care and has created partnerships with the regional Family Care Community Partnerships and the Mental Health Association for social marketing. Events connected with Children's Mental Health Awareness Day and other events have been used to generate broad-based support for expansion.

Cultivating Leaders

Cultivating ongoing leaders and champions for the system of care philosophy and approach to support expansion of the system of care approach (e.g., through training and leadership development activities)

Cultivating leaders generally was not noted as an approach for system of care expansion. However, in Rhode Island, efforts to cultivate leaders for systems of care involve providing training and coaching to community lead agencies. In Maryland, leadership academies and other national meetings have been used as vehicles to develop leaders for the approach. In addition, the Maryland Coalition of Families offers a family leadership institute to support family members in becoming system of care leaders in their communities, in the state, and nationally.

Examples: Cultivating Leaders

Hawaii:

- Leadership development has not been used as an expansion strategy. A leadership development program has been sponsored by the state agency (1 day per week for 10 weeks). The program focused on both the theory and practice of leadership and involved mental health system leaders and family leaders throughout the agency but was not specifically designed to focus on cultivating leaders for systems of care per se.

Maryland:

- Vehicles for leadership development have included leadership academies, bringing key state and local leaders to system of care community meetings, training institutes, and other forums for education, training, and cultivation of leaders for the system of care approach.
- The Maryland Coalition of Families offers a Family Leadership Institute to support family members in becoming leaders in their communities, in the state, and nationally.

Michigan:

- The state has brought Georgetown Technical Assistance Center staff in to do leadership training for state and local system of care leaders funded by Mental Health Block Grant dollars. Follow-up activities are incorporated into the training.

Rhode Island:

- A new focus on cultivating state leaders is being implemented by providing leadership development in training and coaching and through work with community lead agencies The state is exploring the potential use of a university to provide leadership development for state and provider-level system of care leaders.
- The Rhode Island Parent Support Network has worked to cultivate family leadership.
- Some leadership development has occurred by supporting key individuals to attend Georgetown University leadership academies.

Table 9 summarizes the study results. Within each of the core strategy areas, the table shows the sub-strategies found to be most effective and those judged to be underutilized. This table includes several new sub-strategies that were not included in the initial framework but were added at the conclusion of the study based on study results and the input of advisory group members.

Table 9. Summary of Study Results in the Five Core Strategy Areas

I. Implementing Policy, Administrative, and Regulatory Changes

Making state-level policy and regulatory changes that infuse and institutionalize the system of care philosophy and approach into the larger service system to support expansion of the system of care approach

Most Effective Strategies	Underutilized Strategies
• Establishing an organizational locus of system of care management and accountability at the state and local levels • Developing and implementing strategic plans • Developing interagency structures, agreements, and partnerships for coordination and financing • Promulgating rules, regulations, guidelines, standards, and practice protocols • Incorporating the system of care approach as requirements in Requests for Proposals (RFPs) and contracts	• Incorporating the system of care approach in monitoring protocols to monitor compliance with system of care requirements • Enacting legislation that supports the system of care approach

New strategies to add to framework based on information generated through the study:

- Incorporating the system of care approach into data systems for outcome measurement and quality improvement
- Linking with and building on other system change initiatives (e.g., health reform, parity legislation, reforms in other systems)

II. Developing or Expanding Services and Supports Based on the System of Care Philosophy and Approach

Implementing the systemic changes needed to develop and expand a broad array of home- and community-based services and supports that are individualized, coordinated, family driven, youth guided, and culturally and linguistically competent to support expansion of the system of care approach

Most Effective Strategies	Underutilized Strategies
• Creating or expanding the array of home- and community-based services and supports • Creating or expanding an individualized, wraparound approach to service delivery • Creating or expanding CMEs • Creating or expanding care coordination • Implementing family-driven, youth-guided services and expanding family and youth involvement at the service delivery level	• Creating, expanding, or changing the provider network • Creating or expanding the use of evidence-informed and promising practices and practice-based evidence approaches • Improving the cultural and linguistic competence of services • Reducing racial, ethnic, and geographic disparities in service delivery

New strategies to add to framework based on information generated through the study:

- Implementing or expanding the use of technology (e.g., electronic medical records, telemedicine, videoconferencing, e-therapy)

Table 9. Summary of Study Results in the Five Core Strategy Areas (continued)

III. Creating or Improving Financing Strategies	
Creating or improving financing mechanisms and using funding sources more strategically to support the infrastructure and services comprising systems of care to support expansion of the system of care approach	
Most Effective Strategies	**Underutilized Strategies**
• Increasing the use of Medicaid • Increasing the use of federal system of care grants, Mental Health Block Grants, and other federal grants	• Redeploying funds from higher cost to lower cost services • Increasing the use of state mental health and substance use funds • Increasing the use of funds from other child-serving systems • Increasing the use of local funds • Increasing the use of federal entitlements other than Medicaid
New strategies to add to framework based on information generated through the study: • Implementing case rates or other risk-based financing approaches to increase flexibility in financing services and supports • Accessing new financing structures and funding streams (e.g., health reform, parity legislation)	
IV. Providing Training, Technical Assistance, and Coaching	
Implementing workforce development mechanisms to provide ongoing training, TA, and coaching to ensure that providers are prepared and skilled to provide effective services and supports consistent with the system of care philosophy and approach	
Most Effective Strategies	**Underutilized Strategies**
• Providing training, TA, and coaching on the system of care approach • Creating ongoing training and TA capacity	• Providing training, TA, and coaching on evidence-informed and promising practices and practice-based evidence approaches
V. Generating Support	
Generating support among families and youth, high-level decision makers at state and local levels, providers, managed care organizations, and other key leaders to support expansion of the system of care approach	
Most Effective Strategies	**Underutilized Strategies**
• Establishing strong family and youth organizations to support system of care expansion • Generating support among high-level policy makers and administrators at state and local levels	• Using data on outcomes and cost avoidance to promote expansion • Cultivating partnerships with providers, provider organizations, managed care organizations, and other key leaders • Generating support through social marketing and strategic communications • Cultivating leaders and champions for the system of care approach

CHAPTER 4: ADDITIONAL FINDINGS

The following were also identified by the study and are reviewed in this chapter:

1. The strategies judged to be most effective across all five core areas
2. The most significant underutilized strategies that have the potential to impact system of care expansion
3. The roles of system of care communities as partners for system of care expansion
4. Challenges and barriers to expansion efforts
5. Federal supports deemed useful to support this work

MOST SIGNIFICANT STRATEGIES

The strategies presented in Table 10 and discussed below were considered across states to be the most significant and effective strategies across all of the core strategy areas for expanding the approach. These strategies were identified on the basis of responses obtained from the interviewees for each state. This list should not be interpreted to mean that these are the only strategies that were effective or the only strategies that should be used. Each of the states studied used many strategies as part of a comprehensive, multipronged approach to system change.

Table 10. Most Significant Strategies

Most Significant and Effective Strategies
• Incorporating requirements in RFPs, contracts, and regulations • Creating or assigning state and local focal points of management and accountability • Providing training and TA on the system of care approach • Expanding the array of services and supports • Expanding an individualized, wraparound approach to service planning and delivery • Expanding family and youth involvement in services • Creating strong family organizations • Increasing the use of Medicaid financing

Incorporating Requirements in RFPs, Contracts, and Regulations

Incorporating various types of requirements was a frequently used strategy that was considered very important and effective. Actions were taken such as requiring within RFPs and contracts with providers that the system of care approach be used, inserting system of care language in Medicaid regulations, and developing provider manuals and practice protocols based on the system of care approach. This strategy was considered to be effective by respondents, even though most states were not as far along in monitoring the implementation of requirements as they would have liked.

Creating or Assigning a State and Local Locus of Accountability

Within this sample of states, there was a clear locus of accountability for efforts to implement systems of care at the state level and at the county or regional level. This does not diminish the importance of governance groups, coalitions, and interagency policy bodies, but rather speaks to the value of having a clear, strong focal point of management and accountability.

Providing Training and TA on the System of Care Approach

Most of the states in this study had mounted robust programs of training and TA, particularly for providers but also for other key leaders. Training was believed to be significant for improving practice and for creating meaningful, sustainable change. In some states, new organizational entities were created to enhance their capacity to provide ongoing training. Examples of topics covered in training and TA include system of care values and principles, partnerships with families and youth, cultural and linguistic competence, use of the wraparound process, and the use of specific evidence-informed interventions. Training has also focused on what it takes to develop the infrastructure, organizational supports, and governance structures for effective systems of care.

Expanding the Array of Services and Supports

To be consistent with the system of care approach, a service delivery system must have a wide array of services and supports. During the past 25 years, the breadth of the service arrays in communities and states across the country has expanded to include home- and community-based services and many additional supports such as respite care, therapeutic behavioral aide services, mentoring, tutoring, and home- and school-based behavioral interventions. Each of the states in this study made considerable progress in expanding the range of available services and supports. This clearly helped to enhance outcomes for children, youth, and families and, as a consequence, to build support for system of care expansion among a wide range of stakeholders.

Expanding an Individualized, Wraparound Approach to Service Delivery

The wraparound approach puts into practice the values and principles of a system of care at the service delivery (i.e., child or family) level. It is not surprising, therefore, that the states in this study invested heavily in providing training in wraparound approaches and funding for their implementation and that they found this to be a highly significant and effective strategy in their expansion efforts. Closely related to this approach, many states expanded their care management services and created CMEs to provide and manage individualized, coordinated services and supports.

Expanding Family and Youth Involvement in Services

Participation by families in the service delivery process has increased over time in this sample of states and was considered to be essential. Families were key drivers in the development of individualized service plans and were involved in providing peer support and education, often through family organizations. There were indications that youth involvement in services was increasing as well, although this is not yet as developed as family involvement.

Creating and Supporting Strong Family Organizations

In addition to their service delivery roles, family organizations have played a critical role in supporting the expansion of the system of care approach. Each of these states has a strong family organization; in most instances, the states have supported their development and sustainability through contracts. These organizations have been vital to the states' ability to sustain their efforts during difficult economic times. Through their outreach efforts to leaders in the legislative and executive branches, family organizations have successfully kept the issue of children's mental health in the forefront; helped to educate groups about the seriousness of the problem of behavioral, emotional, and mental disorders in children and youth; and provided concrete examples of the value of systems of care in helping families to address these problems.

Increasing the Use of Medicaid Financing

Although the specific strategies used by states differed, a strong and consistent finding was that states increased their ability to support an extensive array of services and supports through the use of Medicaid. Medicaid funding was a significant element in bringing about and sustaining system change during difficult budgetary times. States used different waivers, different options, and different service definitions but were all successful in capitalizing on the opportunities that Medicaid offered to fund important services and supports for children and youth with mental health needs and their families.

MOST SIGNIFICANT UNDERUTILIZED STRATEGIES

Other strategies, considered to be underutilized, also have the potential to have an impact on statewide expansion of systems of care but were not used extensively by most of the states in this sample. As noted, states selected those strategies that were most appropriate in their particular environments, though respondents acknowledged that others could also be helpful. Those strategies deemed particularly promising, although underutilized, are presented in Table 11 and discussed below.

Table 11. Underutilized Strategies

Most Significant Underutilized Strategies
• Incorporating the system of care approach in monitoring protocols to monitor compliance with system of care requirements
• Creating or expanding the use of evidence-informed and promising practices
• Creating or expanding the provider network
• Improving the cultural and linguistic competence of services
• Redeploying funds and using data on cost avoidance
• Increasing the use of state mental health funds, funds from other child serving systems, and local funds
• Generating support through social marketing and strategic communications
• Cultivating leaders and champions for the system of care approach

Incorporating the System of Care Approach in Monitoring Protocols

It is noteworthy that respondents reported a high rate of incorporating the system of care approach in rules, regulations, standards, RFPs, and contracts but less focus on monitoring

compliance with these requirements. The impact of requiring that a system of care approach be used is diminished unless there is good monitoring. In addition to assessing general adherence to the system of care approach, such monitoring can determine the degree of fidelity to various aspects of the approach. Specific areas can then be targeted for improvement and TA. States in this study seem to recognize this and are beginning to enhance their monitoring efforts.

Creating or Expanding the Use of Evidence-Informed and Promising Practices

Less activity was reported for implementing evidence-informed practice than for creating or expanding a broad array of services, care management, and an individualized approach—the essence of a system of care since its beginning. However, the importance of interventions that have empirical support has increasingly been emphasized. The evidence base for specific services and supports has increased dramatically over the past decade, and there are indications in the states studied of growing efforts to incorporate evidence-informed and promising practices into their array of services and supports. States are likely to increasingly integrate evidence-informed care into their service array to improve the effectiveness of services and, ultimately, child, youth, and family outcomes. This can build support for expansion of the system of care approach.

Creating or Expanding the Provider Network

Communities and states continue to struggle with workforce issues. One approach has been to reach out to a broader range of providers, leading to a larger number of service providers on a fee-for-service basis. This expansion allows families have a choice of providers as well as a choice of services. The expansion of provider networks and the emphasis on choice are consistent with the system of care core value of family-driven, youth-guided services. Expanding provider networks can be an effective approach for addressing workforce needs, creating the capacity to provide the broad array of services and supports that is characteristic of the system of care approach, and offering meaningful choices to families and youth. The movement toward CMEs is another illustration of this approach, since these entities typically have the flexibility to expand their provider networks in order to offer a wide range of services and supports.

Improving the Cultural and Linguistic Competence of Services

True system of care development cannot be accomplished without attention to the diversity of the population of children, youth, and families in need of services and to the need for cultural and linguistic competence. The children's mental health field has been a pioneer in framing this issue and in developing approaches to address cultural and linguistic competence. A next step in system of care implementation is to demonstrate that cultural and linguistic competence will improve outcomes and, ultimately, support system of care expansion.

Redeploying Funds and Using Data on Cost Avoidance

The states in this study have had substantial success in reducing the use of residential care at a sizeable cost savings; however, they have had less success in redeploying these funds to home- and community-based services that will further reduce the need for expensive residential care. To some extent this is understandable because the data for the study were collected during difficult economic times. Nevertheless, this economic environment may provide opportunities to divert funds from expensive out-of-home care into home- and community-based care. If data are

collected on the costs avoided through reducing the use of residential care, in combination with data on outcomes for children and families served within systems of care, such savings can be used to support statewide expansion. It is precisely during difficult times such as the present that it is especially important to collect data on cost avoidance and to make the case for more home- and community-based services. This type of data collection and analysis is complex; respondents indicated that they could benefit from resources and TA in this area.

Increasing the Use of State Mental Health Funds, Funds From Other Child-Serving Systems, and Local Funds

The public sector children's mental health system has increased dramatically its dependence on Medicaid funding over the past 20 years. The findings from this study indicate that the states in the sample have become very knowledgeable about Medicaid funding and very skilled in using the opportunities provided by Medicaid to support and expand systems of care. However, it is clear that other sources of funding are also needed to support systems of care. The study found only modest uses of state mental health funds, funds from other systems, and local funds. It is a challenge to effectively reach out to these potential sources of funding while also capitalizing on new opportunities created by such changes as health reform and parity legislation, and also maintaining the use of Medicaid that has been demonstrated in this study. Several states have begun to develop interagency funding strategies and to do joint budgeting across systems. States that are able to leverage their existing funds by creating opportunities and incentives for new fiscal partnerships that cut across service systems at state and local levels are poised to be successful.

Generating Support Through Social Marketing and Strategic Communications

Respondents at the state level rarely identified social marketing as an expansion strategy; however, social marketing and strategic communications cut across most strategies identified as effective. For example, cultivating support among high-level policy and decision makers has been accomplished with targeted information. Such information highlights outcomes achieved at system and service delivery levels using the system of care approach, as well as personal stories of the value of the approach for youth and families. Despite the use of these approaches, there remains a need to spread the word about the mental health needs of children and the value of the system of care approach to address these needs.

The use of social marketing and strategic communications has been characterized in this study as an underutilized strategy. If system of care expansion is to be accomplished and sustained, then public education, social marketing, and strategic communications are needed to support action on behalf of this population of children and youth. Messages must be crafted that are clear, powerful, and tailored to specific audiences. Public education and social marketing campaigns are needed to reach important audiences. States that have done this well have fared better in these difficult financial times than states that have not.

Cultivating Ongoing Leaders and Champions for the System of Care Approach

Understandably, states and communities have been extremely busy managing complex service delivery systems on behalf of children, youth, and families. In addition, they have formed unprecedented partnerships with families and family organizations and are starting to do so with

youth leaders and organizations. This is extremely commendable and bodes well for the expansion of the system of care approach.

Looking to the future, however, new leaders must be identified and prepared at state and local levels. Leaders are needed who are skilled in the system change process; knowledgeable about the system of care approach; able to generate support at the highest levels; and able to create partnerships across systems to improve services for children, youth, and families. States and communities must cultivate champions who are able to communicate convincingly about the system of care approach and have sufficient influence to make a difference. In the past, systems of care have relied heavily on family members and youth to fulfill this role, but champions can also be legislators; civic, business, and faith leaders; leaders from sports, entertainment, or the media; and highly visible individuals such as the first lady in Maryland. Such champions may have great credibility, since they have no personal benefit to derive from improved services and systems. Some champions have been identified as part of the national Children's Mental Health Awareness campaign, and some communities have identified and cultivated influential champions. As a strategy for expanding the system of care approach, states may wish to consider how best to identify such champions, how to cultivate them as advocates for systems of care, and how they can best help with expansion efforts.

STATE–COMMUNITY PARTNERSHIPS FOR EXPANDING THE SYSTEM OF CARE APPROACH

Previous work on sustainability underscored the importance of state–community partnerships to accomplish the goal of widespread adoption of the system of care approach. Both community- and state-level stakeholders agreed that without state involvement, the likelihood of sustaining federally funded systems of care beyond the grant-funded period is significantly diminished. In addition, federal grants are at risk for being reduced to projects that disappear when federal funding is terminated. With state involvement, the policies and financing mechanisms necessary to sustain systems of care after the termination of federal funding are more likely to be implemented, enabling both the maintenance of funded systems of care and the application of the approach statewide to include areas that did not have the benefit of federal funding.

There was also considerable consensus among stakeholders in sustainability studies regarding the importance of the community involvement in sustaining systems of care and expanding them to other areas. In many instances, innovations in implementation originate in communities, which are an invaluable source of experience and expertise that can both inform and facilitate expansion efforts. Ideally, both a top-down approach with policies, goals, and system-level supports for system of care implementation and a bottom-up approach involving the innovation, commitment, and expertise at the community level create the synergy needed to achieve widescale adoption. Thus, both states and communities are central players and have important roles to play in expanding the system of care approach.

Accordingly, an additional purpose of this study was to enhance the understanding of the role of federally funded and graduated CMHI grantees in helping states to expand their systems of care, and the study examined the ways in which communities have partnered with states to contribute to expansion. Communities can and do play a vital and strategic role by testing and piloting approaches that can then be implemented statewide, providing training and TA, providing data to

demonstrate positive outcomes at both system and service delivery levels, generating high-level support, and contributing to the development of statewide family organizations. In addition, having targeted federal funds for systems of care through the CMHI was reported to assist states in leveraging additional resources and implementing system changes.

Although the states studied reached out to and involved their system of care communities, an underutilized strategy is their participation in planning for statewide expansion. This finding was surprising, particularly given the knowledge and experience that they can contribute to the process. In recent years, the CMHI has increased its emphasis on state–community partnerships, which is likely to result in greater involvement of current and graduated grantees in future statewide expansion planning. The four most effective strategies are presented in Table 12 and described below.

Table 12. State–Community Partnerships

State–Community Partnerships and Role of System of Care Communities	
Most Effective Strategies	**Underutilized Strategies**
• Testing, piloting, exploring the feasibility of approaches • Providing training and TA to other communities • Providing data on outcomes to make the case • Contributing to the development of statewide family organizations	• Generating support and commitment from high-level decision makers • Participating in planning for statewide expansion • Providing seasoned leaders who contribute to future expansion efforts

Testing, Piloting, and Demonstrating Approaches for Statewide Implementation

A frequent and effective role that grantees played was serving as a test site for new approaches, including interventions at the system and service delivery levels (e.g., implementing CMEs or child and family teams for service planning and delivery). Testing, in turn, facilitated the broader implementation of these approaches in other communities throughout the state.

Providing Data

A number of states indicated that data on the effectiveness of systems of care, collected both through the national and local evaluations, was helpful in building a case for expansion among high-level policy and decision makers at the state level. System of care grants provided more resources for evaluation than were typically available, which was very helpful within states. The availability of national data through the evaluation was also cited as being helpful to states in demonstrating that systems of care are not only effective but are a national model.

Providing Training and TA

A number of states, such as Maine, North Carolina, and Oklahoma, have been able to provide training and TA in part because of system of care grants. In some instances, states initiated training activities and enlisted current or graduated communities in a systematic approach to provide training and TA to other communities. Several states also provided financing to support this training. In other instances, the expertise developed by local grantees resulted in them reaching out to other communities on their own, or being sought out, for training and TA

throughout their states. The states in which this occurred found it to be extremely helpful and worked to sustain this enhanced training and TA capacity created in system of care communities.

Contributing to the Development of Family and Youth Organizations

Through system of care grants, increased support was provided to family organizations, which are critical to expansion efforts. This support has included funding and opportunities to participate on planning councils, to attend state and national meetings, and to become service providers. Also, CMHI grant resources have been used to support the development of youth leadership and youth organizations within the states.

CHALLENGES AND BARRIERS TO EXPANDING SYSTEMS OF CARE

Respondents were asked to identify challenges and barriers to expanding systems of care. All of the potential challenges explored are shown in Table 13, along with those characterized as the most significant.

Table 13. Challenges to Expanding the System of Care Approach

Challenges and Barriers	
All Challenges	**Most Significant Challenges**
• Fiscal crises and budget cuts • Changes in administration that result in policy changes • Lack of institutionalization of the system of care approach in legislation, plans, regulations, and other policy instruments • Shift in focus to health reform and parity that is not linked to the system of care approach • Inability to obtain Medicaid financing for services and supports • Inability to obtain or redirect other funds for services and supports • Lack of ongoing training • Lack of data to make the case for statewide development of systems of care • Lack of a children's mental health workforce trained in system of care approach • Insufficient buy-in among high-level decision makers at state and local levels • Insufficient buy-in among managed care organizations, program managers, provider agencies, clinicians, and so forth • Insufficient buy-in and shared financing from other child-serving system partners • Lack of support and advocacy among families, family organizations, youth, youth organizations, and advocacy groups	• Fiscal crises and budget cuts • Changes in administration that resulted in policy changes • Insufficient buy-in and financing from other child-serving systems • Lack of a children's mental health workforce trained in the system of care approach • Loss of federal funding and accompanying supports for systems of care

Two barriers stood out as major concerns across states. These were fiscal crises with accompanying budget cuts and changes in administration that could potentially result in policy changes. Although it is not unusual for there to be periodic budget problems in states, the fiscal challenges experienced by states in recent years have been exceptional and have threatened both current and future financing for system of care implementation. It is noteworthy, however, that several states indicated that they were able either to avoid cuts or to minimize the cuts through the support they had from family organizations, support across child-serving systems, data on effectiveness, and ongoing education of key leaders. In addition, some states in the sample described budget problems as both a challenge and an opportunity, noting that policy makers and child-serving agency partners are more amenable to approaches such as blending or braiding funds, redeploying resources from higher cost to lower cost services, and other strategies for better investing scarce resources in difficult economic times.

Administration changes at state and local levels are challenges faced by leaders of public agencies, as they may result in new directions, policies, and priorities. However, states in the study sample have had considerable success in maintaining their gains through various administration changes. This is attributed to the institutionalization of the system or care approach in policy, financing, and practice. In addition, intentional outreach and educational efforts with high-level decision makers in new administrations by system of care leaders and family organizations have helped these states to successfully work through such changes.

Other challenges noted include the lack of a children's mental health workforce adequately trained in the system of care approach and the lack of sufficient buy-in and financing from other child-serving systems. Although there were some outstanding successes in terms of interagency collaboration and financing in the states studied, the issue still loomed for many states.

Several states noted the loss of their federal system of care grants as a barrier. Challenges are created not only by the loss of federal funding but also by the loss of federal TA, meetings, and other supports for system of care implementation.

FEDERAL SUPPORTS FOR SYSTEM OF CARE EXPANSION

The states were asked to identify federally funded information, resources, training, and support they have received that have been helpful in their efforts to expand the system of care approach. The following training, TA, and evaluation resources were identified as particularly helpful across states:

- CMHI system of care community meetings
- System of care training institutes
- Policy academies
- Leadership academies
- Primer hands on training
- Technical assistance materials and resources from TA providers such as the Georgetown University National Technical Assistance Center for Children's Mental Health and the Technical Assistance Partnership for Child and Family Mental Health

- Data collected by grantee communities and analyzed, compiled and reported for the national evaluation of the CMHI
- Data and resources from the Research and Training Centers on Children's Mental Health previously established at the University of South Florida and Portland State University

Similar opportunities were desired in the future, as was specific TA on strategic planning for expanding the system of care approach and on financing.

CHAPTER 5: LESSONS LEARNED FOR EXPANDING THE SYSTEM OF CARE APPROACH

This section summarizes lessons learned about system of care expansion based on the findings from the study. Each state took a different approach to system of care expansion, building on its unique contexts, opportunities, needs, and strengths. However, there are a number of consistent themes that are summarized below to provide guidance to other states, tribes, territories, and communities in their expansion efforts.

LESSONS LEARNED

Establish a Strong Value Base

The states in this study had a strong foundation in system of care values and principles that they were able to build upon in their expansion efforts. In some instances, this foundation was laid in the mid-1980s with the CASSP program of the National Institute of Mental Health. The expansion of systems of care was a long-term and ongoing process, furthered by system of care grants and other factors such as class-action lawsuits. For example, North Carolina started implementing systems of care even before CASSP with the Willie M. lawsuit in 1979. In Hawaii, a CASSP grant resulted in a commitment to the system of care philosophy; when the Felix lawsuit was filed in 1995, it was natural to develop a settlement agreement based on this philosophy. The system of care grant program, begun in 1992, also provided the impetus for adoption of the system of care philosophy in some states and a strong commitment to the approach.

As the amount of funding changes, and as individual leaders come and go, it is clear that one of the key factors in keeping systems of care alive in these states has been a deep commitment by diverse stakeholders, including policy makers, family advocates, and providers, to system of care values and principles.

Create a Plan with Multiple Strategies

All of the states in the study followed some type of plan that included multiple strategies to achieve their expansion goals. Some states had formal strategic plans that were reviewed and updated periodically. Other states proceeded without formal strategic plans but always had a clear vision and some type of document to help guide the effort.

Interviewees emphasized the importance of ensuring that the multiple strategies included in their plans are aligned with one another so that the service expansion, data collection, new funding development, and workforce development efforts all promote system of care expansion. Alignment creates a synergistic effect whereby the combined impact of these actions exceeds the impact that would have been achieved otherwise. The SAMHSA System of Care Expansion Grant program is designed to support state efforts to develop strategic plans specifically focused on statewide system of care expansion.

Cultivate Effective Leadership

Each of the states in the study had strong leadership, both individual and collective, with a vision of what to accomplish and a plan to get the process going. Leadership consisted of formal leaders, such as state directors of children's mental health, directors of family organizations, or directors of other child-serving agencies at the state and local levels. Leadership also came from leaders without direct authority, such as community members and the spouses of key officials. Most importantly, the leadership, whether individual or collective, was strategic and tactical, flexible and adaptive, and inclusive and persistent.

Be Opportunistic and Adaptable

When one looks back, system change can sometimes appear to be more planful than it really was. Clearly, states in this study had strong planning. However, there are always unexpected developments, and these states were also strong at leveraging positive opportunities that emerged unexpectedly and minimizing the negative impact of any unanticipated barriers. Some of the positive opportunities included new grant programs and new waiver opportunities through Medicaid.

Arizona, Hawaii, Michigan, and North Carolina all had class-action lawsuits, maintaining that some class of children and youth (the definition of "class" varied from state to state) with serious mental health challenges were not receiving adequate services. State leaders saw these lawsuits as opportunities to better serve children, youth, and families by strengthening the system of care approach in their states. In North Carolina, where the lawsuit took place before the development of the system of care approach, the leaders seized the opportunity to reform their services and systems—doing so in a way that led the way to systems of care not only throughout North Carolina but around the country.

Contextually, it is also important to remember that data collection for this study took place during a time of great budgetary challenges in all of these states, challenges of a magnitude that could not have been anticipated. The successful states had sound data on the outcomes of their work and powerful partnerships. While most of the states in this study were not able to escape totally unscathed from the financial circumstances, their preparation and ability to adapt helped to keep the damage to a minimum. In fact, in several states, the tight budgets created opportunities to demonstrate that cost-effective, individualized care approaches could reduce the need for more expensive and restrictive residential placements. This is a prime example of converting a potentially serious problem into a positive outcome.

In recent years, both the fields of system change and leadership have emphasized that organizations and systems include many independent agents that operate in complex ways that are not perfectly predictable and that are beyond the control of any one entity. The challenges presented to individuals or groups wishing to make system or organizational changes are to be good observers of what is occurring within their systems or organizations, to create opportunities for systematic review of progress, and to remain open to developing new strategies or modifying existing strategies.

Adhere to High Standards of Quality

Consistent with the emphasis on systems as complex entities with many parts interacting in often unpredictable ways, the system of care grant program and the overall system of care approach have increased the focus on continuous quality improvement and performance measurement. This lesson was clearly reflected in the work of the states in this study. They recognized that expanding systems of care without maintaining adherence to high quality standards could potentially harm the system of care movement and their state's expansion efforts. The establishment of high standards for quality and the implementation of efforts to monitor adherence to them was considered essential.

In some states, the establishment of standards through requirements in RFPs and contracts preceded the quality and outcome measurement efforts. In fact, although it is typical that requirements for adherence to the system of care approach come before the measurement processes, the states in this study are clearly focusing on continuous quality improvement methods, aided in several instances by the national evaluation of the CMHI. Quality standards have also been bolstered in states such as Arizona and Hawaii by their class-action lawsuits. Although these lawsuits typically result in strong requirements for monitoring and reporting compliance to external sources, they also can create exceptional opportunities for states to strengthen their continuous quality improvement procedures.

The effort to enhance the quality of service delivery has also been buttressed in recent years by improvements in measurement. Improvements include measures of fidelity to the wraparound process (Wraparound Fidelity Assessment System), case study approaches that examine overall adherence to system of care principles, and psychometric instruments such as the Child and Adolescent Functional Assessment Scale (CAFAS), and the Child and Adolescent Needs and Strengths scale (CANS). These and other measures are useful both in clinical decision making and outcome measurement.

Partner With Families and Youth

A strong, consistent theme across these states has been the important role of family members and youth in supporting expansion of the system of care approach. The role of family organizations has been particularly notable because they are at a more advanced stage of development in these states than are youth organizations. Family organizations are providing direct services, helping to develop effective policy, and providing oversight of system performance, particularly with regard to the role of the families. Perhaps most importantly, family members have educated key stakeholders about the needs of children and youth with serious mental health challenges; about system of care values and principles; and about the benefits of an individualized, culturally and linguistically competent, strength-based approach to care. They have been enormously valuable advocates in promoting the system of care approach. Family organizations have targeted leaders in legislative and executive branches and have been credited by state leaders for securing new resources and for minimizing the loss of resources during budgetary challenges.

Several of the states, such as Maine and Maryland, have strong youth leaders and organizations. These organizations have provided testimony before legislative groups, offered training to providers, and assisted in developing quality guidelines for direct service providers. The impact

in these states has been extremely positive, and the overall impact of youth leaders and organizations is anticipated only to grow over the coming years.

CONCLUSION

As the findings from this study indicate, there is no single formula or strategy for expanding the system of care approach statewide. The key is for states to incorporate lessons learned from the field and to develop and implement expansion plans that build on their strengths, create partnerships, and capitalize on opportunities. The states studied have made very encouraging progress and have maintained that progress in the face of extreme financial challenges. They also have recognized that many challenges remain.

SAMHSA's System of Care Expansion Planning Grant program to promote widespread adoption of the approach provides a new opportunity to enhance progress that has already been achieved and to support new expansion efforts across the Nation. Other changes such as health reform and modifications in the federal Mental Health Block Grant program and Medicaid may also facilitate the process so that more states can truly achieve a tipping point for broad implementation of the system of care approach. These changes and new initiatives all provide additional opportunities for continuous learning about the critical but complex task of bringing about system change in individual communities and throughout a state, tribe, or territory.

This report is intended to assist states in their efforts to expand the system of care approach in the coming years. These efforts will, in turn, help to further advance the knowledge base for achieving widespread adoption of innovative approaches.

Included in the Appendix are two tools that emerged from the study. The first is the revised strategic framework (displaying the five core strategy areas and sub-strategies) that was refined based on study findings and input from expert advisors. The second is a self-assessment tool that allows states to determine their progress in implementing strategies for expanding the system of care approach. This tool can assist them in identifying both achievements and areas needing further attention that could be included in a comprehensive strategic plan for system of care expansion.

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APPENDIX

Tools for Expanding the System of Care Approach

National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program

STRATEGIC FRAMEWORK FOR EXPANDING THE SYSTEM OF CARE APPROACH: FIVE CORE STRATEGY AREAS AND SUB-STRATEGIES

I. Implementing Policy, Administrative, and Regulatory Changes
Making state-level policy and regulatory changes that infuse and institutionalize the system of care philosophy and approach into the larger service system to support expansion of the system of care approach
Sub-Strategies
• Establishing an organizational locus of system of care management and accountability at state and local levels • Developing and implementing strategic plans • Developing interagency structures, agreements, and partnerships for coordination and financing • Promulgating rules, regulations, guidelines, standards, and practice protocols • Incorporating the system of care approach as requirements in requests for proposals and contracts • Enacting legislation that supports the system of care approach • Incorporating the system of care approach in protocols to monitor compliance with system of care requirements • Incorporating the system of care approach into data systems for outcome measurement and quality improvement • Linking with and building on other system change initiatives (e.g., health reform, parity legislation, reforms in other systems)
II. Developing or Expanding Services and Supports Based on the System of Care Philosophy and Approach
Implementing the systemic changes needed to develop and expand a broad array of home- and community-based services and supports that are individualized, coordinated, family driven, youth guided, and culturally and linguistically competent to support expansion of the system of care approach
Sub-Strategies
• Creating or expanding the array of home- and community-based services and supports • Creating or expanding an individualized, wraparound approach to service delivery • Creating care management entities • Creating or expanding care coordination and care management • Implementing family-driven, youth-guided services and expanding family and youth involvement at the service delivery level • Creating, expanding, or changing the provider network with new providers and by retooling and aligning community and residential providers • Creating or expanding the use of evidence-informed and promising practices and practice-based evidence approaches • Improving the cultural and linguistic competence of services • Reducing racial, ethnic, and geographic disparities in service delivery • Implementing or expanding the use of technology (e.g., electronic medical records, telemedicine, videoconferencing, e-therapy)

III. Creating or Improving Financing Strategies
Creating or improving financing mechanisms and using funding sources more strategically to support the infrastructure and services comprising systems of care to support expansion of the system of care approach
Sub-Strategies
• Increasing the use of Medicaid • Increasing the use of federal system of care grants, Mental Health Block Grants, and other federal grants • Redeploying funds from higher cost to lower cost services • Implementing case rates or other risk-based financing approaches • Increasing the use of state mental health and substance use funds • Increasing the use of funds from other child-serving systems • Increasing the use of local funds • Increasing the use of federal entitlements other than Medicaid • Accessing new financing structures and funding streams (e.g., health reform, parity legislation)
IV. Providing Training, Technical Assistance, and Coaching
Implementing workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared and skilled to provide effective services and supports consistent with the system of care philosophy and approach to support expansion of the system of care approach
Sub-Strategies
• Providing training, technical assistance, and coaching on the system of care approach • Creating ongoing training and technical assistance capacity • Providing training, technical assistance, and coaching on evidence-informed and promising practices and practice-based evidence approaches
V. Generating Support
Generating support among families and youth, high-level decision makers at state and local levels, providers, managed care organizations, and other key leaders to support expansion of the system of care approach
Sub-Strategies
• Establishing strong family and youth organizations to support expansion of the system of care approach • Generating support among high-level policy makers and administrators at state and local levels • Using data on outcomes and cost avoidance to promote expansion of the system of care approach • Cultivating partnerships with providers, provider organizations, managed care organizations, and other key leaders • Generating support through social marketing and strategic communications • Cultivating leaders and champions for the system of care approach
Cross-Cutting Themes Across All Core Strategy Areas: • Family-driven, youth-guided approaches to services and systems • Cultural and linguistic competence in services and systems • Cross-system collaboration in services and systems • Social marketing and strategic communications

Georgetown University National Technical Assistance Center for Children's Mental Health and National Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program

SELF- ASSESSMENT OF STRATEGIES FOR EXPANDING THE SYSTEM OF CARE APPROACH

STATE: **DATE COMPLETED:**

ASSESSMENT COMPLETED BY:
Name:
Title:
Agency:
Daytime Phone:
E-mail Address:

INSTRUCTIONS
This assessment is designed as a self-administered tool to explore the implementation of an array of strategies that may be used by states, tribes, territories, and communities (hereafter referred to as states) to expand the system of care approach, with the goal of implementing the system of care philosophy and approach statewide and throughout tribes and territories. (For your information, the system of care philosophy is detailed in an appendix to this assessment tool.)

No state is expected to use all of the strategies listed below. Rather, each state will employ the mix of strategies deemed most appropriate and effective in their unique context and environment. ***Further, this self-assessment process is not intended to be used as an evaluation, but as a technical assistance tool to identify areas of strength and potential opportunities and to provide a basis for the development of a comprehensive strategic plan for expanding the system of care approach.*** It is intended to measure progress in implementing each strategy; it is not expected that there will be extensive progress in all areas. Rating progress objectively will enhance the usefulness of this tool in creating a strategic plan to move further toward expansion of the system of care approach.

To complete the assessment, rate the ***progress*** that your state has achieved in implementing each strategy that may be used as part of your efforts to expand the system of care approach. If you have purposively not elected to use a particular strategy, mark the box labeled "None."

RATING OF OVERALL PROGRESS TO DATE IN EXPANDING THE SYSTEM OF CARE APPROACH STATEWIDE:

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

I. IMPLEMENTING POLICY, ADMINISTRATIVE, AND REGULATORY CHANGES

Making state-level policy and regulatory changes that infuse and institutionalize the system of care philosophy and approach into the larger service system to support expansion of the system of care approach

1. Establishing an Ongoing Locus of Management and Accountability for Systems of Care

a) Creating or assigning a viable, ongoing focal point of management and accountability at the state level (e.g., agency, office, staff) to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Creating or assigning viable, ongoing focal points of accountability and management at the local level (e.g., agency, office, staff) to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

2. Developing and Implementing Strategic Plans

Developing and implementing strategic plans that establish the system of care philosophy and approach as goals for the state's service delivery system to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

3. Strengthening Interagency Collaboration

a) Developing interagency structures to set policy, guide, and support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Incorporating the system of care philosophy and approach into memoranda of understanding and interagency agreements to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

c) Cultivating strong interagency relationships and partnerships to coordinate and/or finance systems of care to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

4. Promulgating Rules, Regulations, Standards, Guidelines, and Practice Protocols

a) Promulgating rules and regulations that require elements of the system of care philosophy and approach to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Developing guidelines, standards, or practice protocols based on the system of care philosophy and approach to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

5. Incorporating the System of Care Approach in Requests for Proposals (RFPs) and Contracts

Incorporating requirements for elements of the system of care philosophy and approach in RFPs and contracts with providers and managed care organizations to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

6. Enacting Legislation

Passing legislation that supports the system of care philosophy and approach to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

7. Incorporating the System of Care Approach in Monitoring Protocols

Incorporating the system of care philosophy and approach into ~~monitoring~~ protocols to monitor compliance with system of care requirements among providers and managed care organizations to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

8. Implementing Outcome Measurement and Quality Improvement Systems

Incorporating the system of care philosophy and approach into data systems for outcome measurement and quality improvement efforts to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

9. Linking With and Building on Other System Change Initiatives

Linking with and building on existing and emerging system change initiatives in the state (e.g., health reform, parity legislation, reforms in other systems) to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

II. DEVELOPING OR EXPANDING SERVICES AND SUPPORTS BASED ON THE SYSTEM OF CARE PHILOSOPHY AND APPROACH

Implementing the systemic changes needed to develop and expand a broad array of home- and community-based services and supports that are individualized, coordinated, family driven, youth guided, and culturally and linguistically competent to support expansion of the system of care approach

1. Creating or Expanding a Broad Array of Services

Creating or expanding a broad range of home- and community-based services and supports that are consistent with the system of care philosophy and approach to improve outcomes to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

2. Creating or Expanding an Individualized Approach to Service Delivery

Creating or expanding an individualized, wraparound approach to service planning and delivery to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

3. Creating or Expanding Care Management Entities

Creating or expanding care management entities to serve as the focal point of accountability and responsibility for managing the services, costs, and care management for children with intensive service needs and their families to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

4. Creating or Expanding Care Coordination and Care Management

Creating or expanding care coordination and care management approaches to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

5. Creating or Expanding Family-Driven and Youth-Guided Services and Expanding Family and Youth Involvement in Service Delivery

Creating or expanding family-driven and youth-guided services and expanding family and youth involvement in the planning and delivery of their own services to improve outcomes to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

6. Creating, Expanding, or Changing the Provider Network

a) Creating, expanding, or changing the provider network by adding new types of home- and community-based providers, changing licensing and certification, etc. to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Creating, expanding, or changing the provider network by retooling community and residential providers to provide services that are aligned with the system of care philosophy and to diversify the services they offer to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

7. Creating or Expanding the Use of Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches

Creating or expanding the use of evidence-informed and promising practices and practice-based evidence approaches within systems of care that improve outcomes to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

8. Improving the Cultural and Linguistic Competence of Services

Creating or expanding the use of culturally and linguistically competent approaches to service delivery to improve outcomes to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

9. Reducing Racial, Ethnic, and Geographic Disparities in Service Delivery

Developing and implementing strategies directed at reducing racial, ethnic, and geographic disparities in service delivery across child-serving systems to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

10. Implementing or Expanding the Use of Technology

Implementing or expanding the use of technology (e.g., electronic medical records, telemedicine, videoconferencing, e-therapy) to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

III. CREATING OR IMPROVING FINANCING STRATEGIES

Creating or improving financing mechanisms and using funding sources more strategically to support the infrastructure and services comprising systems of care to support expansion of the system of care approach

1. Increasing the Use of Medicaid

Increasing the use of Medicaid to finance services by adding new services, changing existing service definitions, obtaining waivers, using EPSDT, using the rehabilitation option, etc., to finance services and supports to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

2. Increasing the Use of Federal Grants to Finance Systems of Care

a) Maximizing the use of federal system of care grants to develop infrastructure and/or services and to leverage other long-term funding to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Maximizing federal Mental Health Block Grant funds to finance infrastructure and/or services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

c) Maximizing other federal grant funds to finance infrastructure and/or services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

3. Redeploying Funds from Higher-Cost to Lower-Cost Services

Redeploying, redirecting, or shifting funds from higher-cost to lower-cost services to finance infrastructure and/or services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

4. Implementing Case Rates or Other Risk-Based Financing Approaches

Implementing case rates or other risk-based financing approaches to increase flexibility in financing services and supports to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

5. Increasing the Use of State Mental Health and Substance Use Funds

a) Obtaining new or increased state mental health funds to support system of care infrastructure and services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Obtaining new or increased state substance use funds to support system of care infrastructure and services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

6. Increasing the Use of Funds from Other Child-Serving Systems

a) Obtaining new or increased funds from other child-serving agencies to finance infrastructure and/or services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Coordinating, braiding, blending, or pooling funds with other child-serving agencies to finance infrastructure and/or services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

7. Increasing the Use of Local Funds

Obtaining new or increased local funds (e.g., taxing authorities, special funding districts, county funds) to finance infrastructure and/or services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

8. Increasing the Use of Federal Entitlements Other Than Medicaid

Increasing the use of federal entitlements other than Medicaid to finance infrastructure and/or services to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

9. Accessing New Financing Structures and Funding Streams

Accessing new financing structures and funding streams (e.g., health reform, parity legislation) to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

IV. PROVIDING TRAINING, TECHNICAL ASSISTANCE, AND COACHING

Implementing workforce development mechanisms to provide ongoing training, technical assistance, and coaching to ensure that providers are prepared and skilled to provide effective services and supports consistent with the system of care philosophy and approach

1. Providing Training, Technical Assistance, and Coaching on the System of Care Approach

Providing ongoing training, technical assistance, and coaching on the system of care philosophy and approach to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

2. Creating Ongoing Training and Technical Assistance Capacity

Creating the capacity for ongoing training, technical assistance, and coaching on systems of care and evidence-informed services (e.g., institutes, centers of excellence, TA centers, other intermediary organizations, partnerships with higher education) to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

3. Providing Training, Technical Assistance, and Coaching on Evidence-Informed and Promising Practices and Practice-Based Evidence Approaches

Providing ongoing training on evidence-informed and promising practices and practice-based evidence approaches to support high-quality and effective service delivery to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

V. GENERATING SUPPORT

Generating support among families and youth, high-level decision makers at state and local levels, providers, managed care organizations, and other key leaders to support expansion of the system of care approach

1. Establishing Strong Family and Youth Organizations

a) Establishing a strong family organization to support and be involved in expansion of the system of care approach (e.g., through funding, involvement at the system and policy levels, contracting for training and services)

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Establishing a strong youth organization to support and be involved in expansion of the system of care approach (e.g., through funding, involvement at the system and policy levels, contracting for training and services)

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

2. Generating Support Among Administrators and Policy Makers

a) Generating political and policy-level support for the system of care philosophy and approach among high-level administrators and policy makers at the state level for expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Generating political and policy-level support for the system of care philosophy and approach among high-level administrators and policy makers at the local level for expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

3. Using Data

a) Using data on the outcomes of systems of care and services to promote expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Using data on cost avoidance across systems and comparison with high-cost services to promote expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

4. Cultivating Partnerships With Other Key Leaders

a) Cultivating partnerships with provider agency and organization leaders, managed care organizations, etc., to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

b) Cultivating partnerships with civic leaders and other key leaders to support expansion of the system of care approach

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

5. Generating Support Through Social Marketing and Strategic Communications

Informing key constituencies about the value and merits of expanding the system of care approach through social marketing and strategic communications

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

6. Cultivating Leaders

Cultivating ongoing leaders and champions for the system of care philosophy and approach to support expansion of the system of care approach (e.g., through training, leadership development activities)

	0=None	1=Some	2=Moderate	3=Significant	4=Extensive
Rating of Progress:	☐	☐	☐	☐	☐

Notes:

MOST SIGNIFICANT STRATEGIES

Of the strategies above, specify 5 strategies that have been the most significant in your progress in expanding systems of care to date:

1.

2.

3.

4.

5.

STATE–COMMUNITY PARTNERSHIPS FOR EXPANDING THE SYSTEM OF CARE APPROACH

Indicate the ways in which state-community partnerships have been created to support expansion of the system of care approach:

Communities are strategically engaged as partners in system of care expansion to do the following:

- ☐ Test, pilot, demonstrate, and explore the feasibility of approaches to developing and expanding systems of care that can be applied in other communities in the state
- ☐ Provide training and technical assistance to other communities in the state
- ☐ Provide data on the outcomes of systems of care at the system and service delivery levels and cost avoidance for making the case for expanding the system of care approach
- ☐ Participate in planning for expansion of the system of care approach
- ☐ Generate support and commitment for the system of care philosophy and approach among high-level policy makers and administrators
- ☐ Contribute to the development of family organizations in the state

- ☐ Provide seasoned leaders who then contribute to future system of care expansion efforts at the state and/or local levels
- ☐ Other (specify) _____

POTENTIAL CHALLENGES TO STATEWIDE SYSTEM OF CARE EXPANSION

Indicate the potential challenges and barriers to statewide system of care expansion:

- ☐ Fiscal crises and budget cuts
- ☐ Changes in administration or leadership that result in policy changes
- ☐ Lack of institutionalization of the system of care philosophy and approach in legislation, plans, regulations, and other policy instruments
- ☐ Inability to obtain Medicaid financing for services and supports
- ☐ Inability to obtain or redirect other funds for services and supports
- ☐ Lack of data to make the case for statewide development of systems of care
- ☐ Lack of ongoing training
- ☐ Lack of a children's mental health workforce trained in system of care philosophy and approach
- ☐ Insufficient buy-in to the system of care philosophy and approach among high-level administrators and policy makers at the state level
- ☐ Insufficient buy-in to the system of care philosophy and approach among high-level administrators and policy makers at the local level
- ☐ Insufficient buy-in to the system of care philosophy and approach among provider agencies, program managers, clinicians, managed care organizations, etc.
- ☐ Insufficient buy-in and shared financing from other child-serving systems for expansion of the system of care approach
- ☐ Lack of support and advocacy among families, family organizations, youth, youth organizations, advocacy groups, and so forth for expansion of the system of care approach
- ☐ Shift in focus to the implementation of health care reform and parity legislation
- ☐ Lack of coordination and linkage with other system change initiatives in the state (e.g., health reform, parity legislation, reform initiatives in other child-serving systems)
- ☐ Other (specify) _____

APPENDIX

SYSTEM OF CARE CONCEPT AND PHILOSOPHY

DEFINITION

A system of care is:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

CORE VALUES

Systems of care are:

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.

GUIDING PRINCIPLES

Systems of care are designed to:

1. Ensure availability of and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that addresses their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports.
2. Provide individualized services in accordance with the unique potential, strengths, and needs of each child and family, guided by an individualized, “wraparound” service planning process and an individualized service plan developed in true partnership with the child and family.
3. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
4. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
5. Ensure cross-system collaboration, with linkages among child-serving systems and mechanisms for system-level management, coordination, and integrated management of service delivery and costs.
6. Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
7. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
8. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
9. Incorporate or link with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
10. Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
11. Protect the rights of children and families and promote effective advocacy efforts.
12. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these differences.

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